

UC Davis Health

Mandatory Annual Training Manual 2021



MANDATORY ANNUAL TRAINING MANUAL

2021

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Purpose and Goals

This manual updates and reviews annual training topics required for the Health Insurance Portability and Accountability Act (HIPAA), the Joint Commission on Accreditation of Healthcare Organizations (TJC), and Occupational Safety and Health Administration (OSHA). It also includes medical device reporting, patient's rights, Safety Data Sheets (SDS) and workplace safety. The manual has links to associated UC Davis Health Policies as well as web sites.

Objectives

After reviewing this manual, individuals should be able to:

- Identify patient rights.
- Identify components of a safe workplace.
- Discuss environment of care.
- Discuss the importance of infection prevention.

Introduction

UC Davis Health is the only academic health system in the region that views healthcare on a regional, national, and even international level for areas that are vulnerable and need improvement.

Annual training is an opportunity to be current with topics of importance and polish skills that may not have been used recently. Reviews of personal skills and/or information deficits are assisted through regulatory agencies and accreditation organizations. Therefore, the UC Davis Health workforce should take the opportunity to benefit from the work put in by regulatory agencies and the UC Davis Health departments in identifying key areas of focus to provide **person-centered care** in the best way, at the best time, and in the best place – UC Davis Health.

Accreditation

UC Davis Medical Center is accredited and surveyed by several regulatory and accreditation entities that are responsible for: providing oversight and monitoring of healthcare practitioners and facilities, providing information about changes within the healthcare industry, promoting patient safety, and ensuring regulatory compliance and quality services are rendered on behalf of patients. Federal, state, and local regulatory and accreditation agencies establish rules, standards, or guidelines for healthcare facilities and mandate compliance to ensure a culture of safety for all patients, visitors, and healthcare employees.

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Accreditation entities such as The Joint Commission, an independent not-for-profit organization that accredits hospitals on behalf of the Centers for Medicare and Medicaid (CMS), are dedicated to raising the level of quality and safety of healthcare provided through the accreditation or certification process. Accreditation or Program Certification is considered a symbol of quality within the healthcare industry, with the Joint Commission being considered one of the nation's predominant health standards-setting bodies.

National Patient Safety Goals

The Joint Commission is one of nine hospital and health services accrediting agencies accepted by CMS to provide deemed-status in the United States, providing oversight for hospitals and other healthcare facilities.

The 2021 National Patient Safety Goals can be found at:

https://www.jointcommission.org/standards_information/npsgs.aspx

A synopsis of the National Patient Safety Goals is in Appendix A.

Emergency Codes

UC Davis Health uses several codes to announce events that require an urgent response:

- Code Blue for medical emergency
- Code Rainbow for child abduction
- Code Red for fire
- Code Pink for newborn emergency event
- Code C for emergency cesarean section
- Code Elopement for patients attempting to leave the hospital prior to medical clearance and discharge
- Code Triage for Emergency Department Decompression
- Active Shooter for persons actively attempting to harm or kill others
- Code Green for internal or external disasters

Each of these codes has a different response protocol. UC Davis Health workforce should speak with their managers about the purpose of each code, and their potential role in responding to each of them.

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Emergency Management

The goal of emergency management in a healthcare setting is to continue to provide quality care to all patients in a safe environment, regardless of the incident, event, or disaster situation. Staff will use the Hospital Incident Command System (HICS) in the UC Davis Health Hospital Command Center (HCC) to organize the response, assign roles, and assess the situation – what happened, how it impacted the organization, and to determine priority response actions.

The Continuity of Operations Plan (COOP) describes how UC Davis Health will respond to all types of emergencies as an organization. Disaster exercises to test the effectiveness of the Emergency Operations Plan are held throughout the year – get involved, participate in the next exercise!

[Click here to see the most current version of the COOP.](#)

UC Davis Health staff form an integral part of all emergency response. All workers should speak with their manager about their department's role in a disaster response.

A red Disaster Manual containing specific instructions for the unit is maintained in each department. UC Davis Health workforce should be familiar with the manual and its contents – ask your department manager for more details. [Click here to see the updated red Disaster Manual contents.](#)

Contact the Emergency Management office at (916) 734-8261 with any questions.

Notification and Response

UC Davis Health alerts staff of urgent situations through overhead paging, phone calls, texts, and email. Some of these alerts are from the WarnMe system. WarnMe messages go to phone numbers and email addresses that UC Davis Health workforce choose, but it will default to their ucdavis.edu email account. To personalize your WarnMe notifications visit this website:

http://intranet.ucdmc.ucdavis.edu/emergencypreparedness/warn_me.shtml

To receive Sacramento County emergency alert notifications visit this website: www.Sacramento-Alert.org

Code Green

Code Green is for incidents taking place within the hospital and the community. Widespread disasters or other situations may dramatically increase the number of patients arriving at the hospital and/or may affect the ability of the hospital to function or provide patient care. Examples are a mass casualty event like a multi-vehicle crash, a flood that disrupts traffic and interrupts supply deliveries, or any slow- or fast-moving event resulting in injury to or infection of a large number of people.

Staff Roles and Responsibilities

Department managers and supervisors have the ultimate responsibility to implement the emergency management plan at the department level. Refer to the department unit's red Disaster Manual for

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specific information on the unit's role and responsibilities in a disaster. The red binder contains links to the Continuity of Operations Plan/Emergency Operations Plan, Facility Evacuation policy, the Fire and Evacuation or Relocation Plan for the building or area, and the department specific emergency plan(s). It is essential that UC Davis Health workforce become familiar with their department's emergency plans and procedures.

An individual's role and reporting structure may or may not change in a disaster. If there is a major event, report to your usual supervisor at the next scheduled shift unless specifically instructed otherwise.

Personal Preparedness

UC Davis Health workforce regularly prepare for disasters at work, so that continuity of care for all patients is not disrupted. Preparedness should also include readiness for situations that arise outside of work. UC Davis Health's Personal Preparedness website has information to help employees and their families prepare for the unexpected.

The site includes information and a checklist based on recommendations from the American Red Cross, Federal Emergency Management Agency (FEMA) and regional emergency response organizations. The experts recommend the following three basics:

- Have an emergency kit and "grab and go" bag in the home, office, and car
- Have a plan to get out, meet up, and communicate with family
- Have a way to stay informed of emerging and changing situations

For additional information visit the Personal Preparedness website:

http://intranet.ucdmc.ucdavis.edu/emergencypreparedness/personal_preparedness.shtml

Evacuation Procedures

Hospital buildings are designed to defend in place, permit time to extinguish a fire, and to move patients to safety, if needed. The preferred order of occupant-protection strategies in case of fire or a hazardous condition in the hospital buildings is to:

- (1) Defend in place or shelter in place – stay where you are
- (2) Horizontal Relocation – move to another smoke compartment on the same floor
- (3) Vertical Relocation – move to another smoke compartment on a different floor
- (4) Evacuation from the building – patients will be staged for evacuation. Elevators will be used first, and other evacuation equipment will be used only if necessary.

The decision to relocate within the hospital or evacuate from a non-hospital building can be authorized by on-site management (charge nurse, manager, nursing supervisor, practice manager, associate

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medical director, building coordinator, or building manager) or emergency responders. Code Green will be initiated for any incident that triggers the relocation or evacuation of inpatients. The decision to evacuate an entire wing or the whole hospital can only be authorized by the Hospital Incident Commander.

Be familiar with exit routes as indicated in evacuation plans and departmental emergency response plans located in the red Disaster Binder. If directed, move patients away from immediate danger and, if necessary, request assistance when moving patients. Remember to reassure patients when moving them – their safety and the safety of our staff is our highest priority.

Management of the Environment of Care

The goal of management of the environment of care and of emergency management is to provide a safe, functional, supportive and effective environment for patients, staff members, and other individuals in the hospital. Effective management includes using processes and activities to:

- Reduce and control environmental hazards
- Prevent accidents and injuries
- Maintain safe conditions for patients, visitors and staff
- Maintain an environment that is sensitive to patients' needs for comfort, social interaction, positive distraction and self-control
- Maintain an environment that minimizes unnecessary environmental stresses for patients, visitors and staff

The Joint Commission identifies six environments of care management plans. They are:

1. Safety Management
2. Hazardous Materials and Waste Management
3. Fire Prevention Management
4. Security Management
5. Medical Equipment Management
6. Utility Systems Management

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Workplace Safety

Most safety related services are provided by Environmental Health & Safety and Health Physics. Services are available by calling the numbers listed or by referring to the campus phone directory, or e-mailing EH&S at safety@ucdavis.edu

EH&S (Occupational Safety) 916-734-2740

Health Physics 916-734-3355

The Health System's Safety Management Plan guides implementation of the safety program including plans for preventing exposure to airborne and blood borne pathogens, prevention of ergonomic injuries and safety measures for other common hazards. Copies of the Safety Management Plan are available on the [Environmental Health and Safety](#) website or by calling EH&S.

UC Davis Health workforce can access the Environmental Health and Safety web site from the intranet by typing "safety" in their web browser address bar. The Safety Management Plan sets the standard for safety management and is complemented by departmental safety programs and activities.

Implementation of the Plan is a requirement of Federal and State regulations and of [UC Davis Health Policy 1620 Departmental Injury Prevention Plan and Safety Coordinators](#). The Safety Committee and Health and Safety Officer play vital roles in ensuring the effective implementation of the plan.

Department managers and supervisors implement the plan at the department level. Refer to the green Injury Prevention Plan binder in the department for more information on safety activities in the department. The department will also have a safety coordinator, who plays a key role assisting with identification of safety hazards and distribution of safety information.

Safety Training

Training is important for safety. Staffs will need to take a refresher on this training every year and department and job specific safety training, which may be provided in a variety of ways including drills, in-services, bulletin board postings and educational posters. UC Davis Health workforce are encouraged to ask questions if they are unsure on how to perform a job safely.

Hazard Identification and Reporting

Work locations are inspected regularly, and deficiencies noted by EH&S or by department Safety Coordinators. After an inspection, UC Davis Health workforce may be required to implement corrective actions. UC Davis Health workforce are encouraged to report hazards to their supervisor or safety coordinator. UC Davis Health workforce may also report hazards directly to EH&S by phone, email or using the on-line incident reporting system or by completing a Hazard Report Form (available as [UC Davis Health Policy 1605, attachment 1](#)).

Hazard Report Forms may be submitted anonymously through the UC Davis Health mail system. If other methods of reporting and correcting workplace hazards are not successful, UC Davis Health workforce

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have the right to contact Cal/OSHA or The Joint Commission. Employees may not be disciplined for reporting problems in this manner.

If the hazard represents an emergency, arrange to have someone stay by the location to warn others, if necessary, and call 9-1-1.

Injuries and Accidents

As a part of the safety program accidents are investigated and corrective actions implemented to prevent future incidents.

Occupational Injury or Illness

Report any occupational injury or illness, to supervisors as soon as possible. For a non-emergency workplace injury that requires the attention of a doctor or nurse, call Employee Health Services for an appointment. If after hours and the injury needs to be seen, go to the Urgent Care Clinic. Call Employee Health at 916-734-3572 to obtain information and numbers regarding the Urgent Care Clinic (information on the Urgent Care Clinic is included in their after-hours phone message). Incidents associated with occupational injury or illnesses are to be reported via the Worker's Compensation System, not via the online Incident Report System.

Call 9-1-1 for emergency medical care or, if in the hospital, go to the emergency department. Property damage involving a University owned vehicle requires an Auto Accident Form be completed and forwarded to Fleet Services within 24 hours. Additionally, the accident must be reported to the University's third-party claims administrator, Sedgwick CMS, by calling 1-800-416-4029.

Incidents Involving Patient or Visitor Injury

Notify supervisors of any incidents involving patient or visitor injury and report immediately via the on-line incident reporting system.

Indoor Trip and Fall Hazards

Keep exits, stairways and hallways free from stored items and debris. Submit a service request to PO&M for problems that are not an immediate threat to safety such as a light that is out, loose carpets, loose tiles, and cracked or torn linoleum. All routine service requests must be submitted via the online Service Request System, BEATS. Urgent requests may be placed by calling 916-734-2763. The link to BEATS is available on the front intranet page of The Insider. From the "On-the-Job Resources" section, select "Administration", scroll down and click on "BEATS On-Line Service Request System". Report spilled liquids (coffee, soda, etc.) to Environmental Services, 916-734-3777.

Outdoor Trip and Fall Hazards

Report to PO&M, using the process described above, damaged pavements, sidewalks, driveways and parking lots. Follow up with a call to Environmental Health & Safety (EH&S), 916-734-2740.

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Smoke and Tobacco-Free Campus

The UC Davis Health buildings in Sacramento and all clinics are a completely smoke and tobacco-free environment. Smoking and tobacco use (including cigarettes, smokeless tobacco, and E-cigarettes) is prohibited in all buildings and outdoor areas on both the Davis and Sacramento campuses. UC Davis' No Smoking and Tobacco-Free Policy, [UC Davis Health Policy 1628](#), provides details of the no-smoking and tobacco-free policy. Individuals who witness an employee smoking or using tobacco on the Sacramento campus may report the violation to that employee's department or patient's clinical unit. [The Healthy UC Davis Smoke and Tobacco-Free website](#) has resources to support all staff for Tobacco-Free Work, including tobacco cessation resources, free nicotine lozenges for staff or visitors, an online Tobacco Tracker reporting tool, and manager/supervisor resources.

Use of Cell Phones

In areas where there are signs indicating "Cell Phones Must Be Turned OFF", cell phone must be POWERED OFF, not simply in vibrate or silence mode. "Airplane" mode with Wi-Fi ON is acceptable in "OFF" areas.

Three-Foot Rule: cell phone users, when conversing on their cell phones, shall stay a minimum of three feet away from all medical devices and instrumented patients (patients connected to medical devices). Three feet is approximately the length of the adult arm. Cell phone use, in accordance with the three-foot rule, is allowed in all areas of UC Davis Health, except where signs indicate that cell phones must be turned OFF or UC Davis Health staff indicates that cell phones must be turned off.

Furthermore, cellular devices should never be placed on medical devices. If interference between a cellular device and a medical device is noted, the cellular device should be turned off or moved to a location greater than three meters (10 feet) from the medical equipment, and Clinical Engineering should be notified (916-734-2846). For additional information on cell phone use, refer to [UC Davis Health Policy 1331](#) for details of the cell phone policy.

Proper Footwear

Wear properly fitted closed-toe shoes. Low-heeled shoes with slip resistant soles help prevent slips and falls, especially in rainy weather and in wet work locations. It is UC Davis Health workforce responsibility to wear and maintain any special safety shoes required for the job.

Safety Management Conclusion

The most valuable UC Davis Health resource is its people, whose wellbeing and productivity is supported by a safe working environment. The following is information on how UC Davis Health workforce can participate in their safety and the safety of others.

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- First: Correct and report safety hazards;
- Get involved in the department's safety program; and
- UC Davis Health workforce should know their job and perform it safely.
- Second: Practice prevention by knowing and avoiding hazards.
- Remember, safety is everyone's responsibility

Hazardous Materials and Waste Management

If UC Davis Health workforce work with Hazardous Materials, their department will train them on the use of those materials, required protective equipment, proper disposal and spill response. Notify the supervisor if additional information is needed before working with the hazardous material.

Safety Data Sheets (SDSs)

How to Read a Safety Data Sheet (SDS)

A safety data sheet (SDS) includes the following information, in sections labeled 1-11 and 16. If no relevant information is found for any given subheading within a section, the SDS shall clearly indicate that no applicable information is available. Sections 12-15 may be included in the SDS but are not mandatory.

1. Identification

- Product identifier used on the label;
- Other means of identification;
- Recommended use of the chemical and restrictions on use;
- Name, address, and telephone number of the chemical manufacturer, importer, or other responsible party;
- Emergency phone number.

2. Hazard(s) identification

- Classification of the chemical in accordance with paragraph (d) of §1910.1200;
- Signal word, hazard statement(s), symbol(s) and precautionary statement(s) in accordance with paragraph (f) of §1910.1200. (Hazard symbols may be provided as graphical reproductions in black and white or the name of the symbol, e.g. flame, skull and crossbones);
- Describe any hazards not otherwise classified that have been identified during the classification process;
- Where an ingredient with unknown acute toxicity is used in a mixture at a concentration = 1% and the mixture is not classified based on testing of the mixture as a whole, a

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statement that X% of the mixture consists of ingredient(s) of unknown acute toxicity is required.

3. Composition/information on ingredients

For Substances:

- Chemical name;
- Common name and synonyms;
- CAS number and other unique identifiers;
- Impurities and stabilizing additives which are themselves classified and which contribute to the classification of the substance.

For Mixtures:

In addition to the information required for substances:

- The chemical name and concentration (exact percentage) or concentration ranges of all ingredients which are classified as health hazards in accordance with paragraph (d) of §1910.1200 and
- Are present above their cut-off/concentration limits; or
- Present a health risk below the cut-off/concentration limits.
- The concentration (exact percentage) shall be specified unless a trade secret claim is made in accordance with paragraph (i) of §1910.1200, when there is batch-to-batch variability in the production of a mixture, or for a group of substantially similar mixtures (See A.0.5.1.2) with similar chemical composition. In these cases, concentration ranges may be used.

For All Chemicals Where a Trade Secret Is Claimed:

- Where a trade secret is claimed in accordance with paragraph (i) of §1910.1200, a statement that the specific chemical identity and/or exact percentage (concentration) of composition has been withheld as a trade secret is required.

4. First-aid measures

- Description of necessary measures subdivided according to the different routes of exposure, i.e., inhalation, skin and eye contact, and ingestion.
- Most important symptoms/effects, acute and delayed.
- Indication of immediate medical attention and special treatment needed, if necessary.

5. Fire-fighting measures

- Suitable (and unsuitable) extinguishing media.

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- Specific hazards arising from the chemical (e.g. nature of any hazardous combustion products).
- Special protective equipment and precautions for fire-fighters.

6. Accidental release measures

- Personal precautions, protective equipment, and emergency procedures.
- Methods and materials for containment and cleaning up.

7. Handling and storage

- Precautions for safe handling.
- Conditions for safe storage, including any incompatibilities.

8. Exposure controls/personal protection

- OSHA permissible exposure limit (PEL), American Conference of Governmental Industrial Hygienists (ACGIH) Threshold Limit Value (TLV), and any other exposure limit used or recommended by the chemical manufacturer, importer, or employer preparing the safety data sheet, where available.
- Appropriate engineering controls.
- Individual protection measures, such as personal protective equipment.

9. Physical and chemical properties

- Appearance (physical state, color, etc.)
- Odor
- Odor threshold
- pH
- Melting point/freezing point
- Initial boiling point and boiling range
- Flash point
- Evaporation rate
- Flammability (solid, gas)
- Upper/lower flammability or explosive limits;
- Vapor pressure
- Vapor density
- Relative density
- Solubility(ies)
- Partition coefficient: n-octanol/water
- Auto-ignition temperature
- Decomposition temperature

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- Viscosity

10. Stability and reactivity

- Reactivity;
- Chemical stability;
- Possibility of hazardous reactions;
- Conditions to avoid (e.g. static discharge, shock, or vibration);
- Incompatible materials;
- Hazardous decomposition products.

11. Toxicological information

- Description of the various toxicological (health) effects and the available data used to identify those effects, including:
- Information on the likely routes of exposure (inhalation, ingestion, skin, and eye contact);
- Symptoms related to the physical, chemical and toxicological characteristics;
- Delayed and immediate effects and also chronic effects from short- and long-term exposure;
- Numerical measures of toxicity (such as acute toxicity estimates).
- Whether the hazardous chemical is listed in the National Toxicology Program (NTP) Report on Carcinogens (latest edition) or has been found to be a potential carcinogen in the International Agency for Research on Cancer (IARC) Monographs (latest edition), or by OSHA.

12. Ecological information (Non-mandatory)

- Adverse effects (such as hazardous to the ozone layer)

13. Disposal considerations (Non-mandatory)

- Description of waste residues and information on their safe handling and methods of disposal, including the disposal of any contaminated packaging.

14. Transport information (Non-mandatory)

- UN number
- UN proper shipping name
- Transport hazard class(es)
- Packing group, if applicable
- Environmental hazards [e.g. Marine pollutant (Yes/No)]
- Transport in bulk (according to Annex II of MARPOL 73/78 and the IBC Code)

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- Special precautions which a user needs to be aware of, or needs to comply with, in connection with transport or conveyance either within or outside their premises

15. Regulatory information (Non-mandatory)

- Safety, health, and environmental regulations specific for the product in question.

16. Other information, including date of preparation or last revision

- The date of preparation of the SDS or the last change to it.

Hazardous Material Labeling Elements

The following information must be included on hazardous materials labels:

Product Identifier: a chemical name, code number, or batch number which identifies the hazardous chemical. The manufacturer, importer or distributor can decide the appropriate product identifier. The same product identifier must be both on the label and in Section 1 of the SDS (Identification).

Signal word: a single word used to indicate the relative level of severity of hazard and alert the reader to a potential hazard on the label. The signal words used are "danger" and "warning." "Danger" is used for the more severe hazards, while "warning" is used for less severe hazards.

Pictogram: a symbol plus other graphic elements, such as a border, background pattern, or color that is intended to convey specific information about the hazards of a chemical. Each pictogram consists of a different symbol on a white background within a red square frame set on a point (i.e., a red diamond). There are nine pictograms under the GHS. However, only eight pictograms are required under the HCS.

Hazard Statement: a statement assigned to a hazard class and category that describes the nature of the hazard(s) of a chemical, including, where appropriate, the degree of hazard.

Precautionary Statement: a phrase that describes recommended measures to be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical or improper storage or handling of a hazardous chemical. When there are similar precautionary statements for chemicals with multiple hazards, the most protective information will be included on the label.

Name, address and phone number of the chemical manufacturer, distributor, or importer.










Information on the labels can be used to ensure proper storage of hazardous chemicals and may also be used to quickly locate information on first aid when needed by employees or emergency personnel. Where a chemical has multiple hazards, different pictograms are used to identify the various hazards.

Information on the labels is related to the information on the SDS; for example, the precautionary statements on the label would be the same as on the SDS. If product label is different than SDS, you must follow product labeling requirements first.

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Pictograms and Hazard Classes

OSHA's required pictograms on hazardous material containers are being standardized and are presented below. The pictograms must be in the shape of a square set at a point and include a black hazard symbol on a white background with a red frame sufficiently wide enough to be clearly visible. OSHA has designated eight pictograms under this standard for application to a hazard category.

 <p>Oxidizers</p>	 <p>Flammables Self-Reactive Pyrophorics Self-Heating Emits Flammable Gas Organic Peroxides</p>	 <p>Explosives Self-Reactive Organic Peroxides</p>
 <p>Acute toxicity (severe)</p>	 <p>Corrosives</p>	 <p>Gases Under Pressure</p>
 <p>Carcinogen Respiratory Sensitizer Reproductive Toxicity Target Organ Toxicity Mutagenicity Aspiration Toxicity</p>	 <p>Environmental Toxicity</p>	 <p>Irritant Dermal Sensitizer Acute toxicity (harmful) Narcotic Effects Respiratory Tract Irritation</p>

Spill Response

If UC Davis Health workforce work with hazardous materials, make sure they know chemical emergency information such as the location of the emergency eyewash and spill kit. For a spill, immediately assess whether the spill is a non-hazardous material, an identifiable hazardous material or an unknown. For

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unknown materials or for hazardous materials exceeding capabilities to respond, call 911 and isolate the area. Stay in a safe location near the spill to provide information to responders. Avoid the possibility of spreading contamination beyond the affected area. Report details of the incident to EH&S via a phone call to 916-734-2740, by using the on-line incident reporting system or by completing a Hazardous Material Incident Checklist (available as [UC Davis Health Policy 1725, attachment 1](#)). All staff should know how to respond to a Code White, indicating a hazardous material emergency, usually involving a chemical spill. Follow the directions of response personnel and stay out of affected areas. Be prepared to take an alternate route if the normal paths are closed during a response. For additional information see [Response to Hazardous Substance Spills UC Davis Health Policy 1725](#) and [UC Davis Health Policy 1623 Management of Hazardous Drug Waste and Spills](#).

Exposure Control and Engineering Controls

To reduce UC Davis Health workforce exposure to hazardous material the following rules can be applied: reduce the hazard class of the material whenever possible by substituting a less hazardous material, reduce the time of exposure, increase the distance from the hazard, and wear protective equipment as required. The proper operation and use of engineering controls, such as biological safety cabinets and fume hoods, is vital to assure everyone's safety and protection against workplace hazards.

Cancer Causing Materials

Cancer causing materials, such as asbestos or ionizing radiation, may be used or be present in UC Davis Health workforce work area. Know these materials and treat them with respect. Refer to the section titled "What You Should Know About Asbestos" for additional information regarding asbestos in UC Davis Health buildings. Information about the safe use of ionizing radiation is available in the UC Davis Radiation Safety Manual. Some hazardous drugs may also cause cancer. Information on hazardous drugs is included below.

Code White: Chemical Spill Response

Code White indicates a hazardous material emergency, usually involving a chemical spill. Follow the directions of response personnel and stay out of affected areas. Be prepared to take an alternate route if the normal path is closed during a response.

Managing Drugs – Employee Exposure, Spills, and Waste

What is a hazardous drug?

Hazardous drug is a new term used to refer to many drugs that may cause health effects from exposures at work and include some commonly used drugs, such as drugs that kill cancer cells (chemotherapy or antineoplastic drugs). A list of hazardous drugs used at UC Davis Health is included as an attachment to [UC Davis Health Policy 10001](#), which governs the use of hazardous drugs. Hazardous drugs should only be handled by staff that have received appropriate training. If in doubt, treat all drugs as hazardous drugs.

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Health risks of hazardous drugs

The most common route of exposure is through the skin, especially by handling the drugs. Hazardous drugs may cause health effects, such as cancer, damage to your genes (your DNA) or body organs, can cause a pregnant woman to have a baby that does not develop properly or affect the ability of both men and women to have children. Short term health effects such as rash, hair loss and nausea are also possible, but are seen with high exposures (such as in patients who are receiving the drugs in chemotherapy).

Minimize exposure to hazardous drugs by following proper work practices

Assume all drugs are hazardous drugs unless you know otherwise.

Do not handle drugs or clean up spills involving drugs unless you have received appropriate training. Obey signs that restrict entry to spill cleanup areas and to specific hazardous drugs work areas.

Drug spills and waste

[UC Davis Health Policy 1630](#) on management of all types of pharmaceutical waste. [UC Davis Health Policy 1623](#) gives detailed instructions for hazardous drug spills and waste disposal. The presence of a liquid or powder in an area where hazardous drugs are handled is the most likely sign of a spill. Do not rely on odor or other such indicators.

Pharmacy and patient care areas are responsible for the appropriate handling of waste pharmaceuticals. With few exceptions, disposing of waste pharmaceuticals in the sink, toilet or trash is prohibited. Non-hazardous waste pharmaceutical containers in patient care areas are disposed of in blue containers and hazardous waste pharmaceutical containers are disposed of in black containers. Additional information is available on the [EH&S website](#).

Cryogenic Liquid Management

Cryogenic liquids, usually liquid nitrogen, are used in many areas of the Health System, particularly in laboratories. Inappropriate handling of cryogenic liquids can lead to skin burns and frostbite (due to extremely low temperatures), container ruptures, and asphyxiation from oxygen displacement if large quantities of the liquid are released into a room. Personnel handling or transferring cryogenic fluids must wear appropriate personnel protective equipment, including, chemical splash goggles, face shield, loose-fitting waterproof cryogenic gloves, and lab coat or cryogenic apron. Safe work practice information is available at [UC Davis Health Policy 1624 Safe Management of Cryogenic Liquid](#). A training presentation is available in the Hazardous Materials section of the [EH&S](#) website.

Liquid oxygen poses special hazards. In addition to stored pressure and burn hazards, it is a concentrated oxidizer. When exposed to liquid oxygen, most organic materials are extremely easy to ignite, and some will even detonate (such as asphalt). Oils, greases, clothing, bed linens, plant material, and plastics should never come into contact with liquid oxygen.

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Oxygen and Other Compressed Gas Cylinders

Compressed gas cylinders are used in healthcare and many research and support activities. Cylinders present significant hazards due to high pressure gases contained within the cylinders which contain oxygen and other oxidizers that may contribute to fire hazards. See [UC Davis Health Policy 1685](#) for specific rules on storage, transportation, and use of oxygen cylinders. Persons using or handling cylinders should have basic training including review of operating and safety protocols for tasks to be performed; review of appropriate Safety Data Sheets (SDS) for toxic gases; and hands-on training by an experienced gas cylinder user. Transport cylinders larger than lecture bottle size with a hand truck or cylinder cart. Rolling or "walking" cylinders are extremely hazardous. Never transport a cylinder with a regulator attached! Always protect the valve during transport by replacing the valve cover. Cylinders must never be left without some type of physical support or restraint such as a stand, a cart, or a cylinder storage rack. Store cylinders in a well-ventilated area away from ignition sources. In addition to the requirements for compressed gas cylinder storage, oxygen cylinders must be further segregated in a designated and approved space as FULL, PARTIAL, and EMPTY, with the appropriate markings over the storage rack. For example:



Empty cylinders must be stored in a room separate from the storage room used for full and partial cylinders.

Additional information on the management and storage of Compressed Gas Cylinders is available in [Safety Net #60](#). Report gas cylinder problems to Distribution (916-703-4040) with follow up to EH&S. For help understanding limitations on the storage of cylinders in buildings; contact Fire Prevention at 916-734-3036.

Review [UC Davis Health Policy 1685 Handling and Storage of Compressed Medical Gas](#).

Hazardous Waste, Medical Waste Management, and Battery Recycling

EH&S provides hazardous waste pick-up and disposal services:

Chemical waste pick up – call EH&S at 916-734-2740.

Label all chemical waste – download the Hazardous Waste Container Label from the EH&S website (type safety in the web browser address bar to locate the EH&S website) to print labels. UC Davis Health workforce are encouraged to use Word to prepare labels for recurring waste streams, but do not modify the categories or other text, as the labels are designed to meet regulatory requirements. Be sure to fill in the date, location, EPA ID number, chemical contents, and concentration on the label and secure it to

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the waste container before beginning to fill it with waste. It is against the law to have waste in an unlabeled container!

Radioactive waste pick-up – call Health Physics at 916-734-3355.

Medical Waste Management

Medical Waste means any biohazardous, pathology, trace chemotherapy, and pharmaceutical waste not regulated by the Federal Resource Conservation and Recovery Act of 1976 (RCRA).

- A) Biohazardous waste – at the point of disposal contains recognizable fluid human blood, fluid blood products, containers or equipment containing blood or blood from animals known to be infected or potentially infected with pathogen that are highly communicable to humans. All biohazardous waste must be placed in red biohazardous waste bags. Red bags must be contained in a hard-sided secondary container with tight fitting lid and have international biohazard symbol on the sides and lid.
- B) Pathology waste – comprised of specimens or tissues that have fixed in formaldehyde or other fixatives. Pathology waste shall be red bagged and immediately placed in a designated “Pathology Waste” container, which is typically around 20-gallon container marked “PATH – Incineration Only”.
- C) Sharps waste – any device having acute rigid corners, edges, or protuberances capable of cutting or piercing. Sharps waste is typically disposed of in a blue pharmaceutical waste container. Laboratory areas may dispose sharps only waste in an appropriate rigid puncture-resistant sharps container.
- D) Trace Chemotherapy waste – items contaminated through contact, or having previously contained chemotherapeutic agents, including but not limited to, gloves, disposable gowns, towels, and intravenous solution bags, and attached tubing that is empty. Trace chemotherapy waste must be placed in a rigid yellow container. Note: Waste must be handled as hazardous waste, rather than medical waste, if it contains chemotherapy agent that can be poured out (for liquids) or scraped out (for solids).

Medical waste pickup is performed by EVS or a vendor (Stericycle). Medical waste (includes red biohazardous waste containers, sharps waste containers, blue pharmaceutical waste containers, pathology waste containers, and yellow trace chemotherapy containers) call Environmental Services at 916-734-3777 to request for pick-up.

Battery Recycling Program

EH&S also provides information and services related to battery recycling. Recycling and pick up request instructions are available on the EH&S website.

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Batteries cannot be thrown into trash, red bags, or sharps containers. EH&S can accept all types of batteries except wet lead-acid (automotive batteries), which can generally be handled by Fleet Services. Clinical Engineering manages sealed lead-acid batteries.

To recycle batteries:

- Establish a collection station. Containers are available through Infor Lawson: item number is 119367. EH&S does not provide containers.
- The container must be labeled using labels and instructions available on the [EH&S website](#).
- Dissimilar battery chemistries should be prevented from contacting each other using individual plastic bags or by placing electrical tape over the terminals.
- Fill out a battery waste pick up request form online: visit the Environmental Health and Safety website (type “safety” into the web browser address bar) and click on Battery Recycling under Quick Links.
- Request a pickup within nine months of the accumulation start date. EH&S will take the entire container and will not leave a replacement.

Eyewash and Emergency Shower Station

An eyewash station and emergency shower station must be available within 10 walking seconds (approximately 55 feet) from where employee may encounter or use hazardous substance which can cause corrosion, severe irritation, or permanent tissue damage to the eyes. The path of travel from the hazard should be free of obstructions. PO&M coordinates vendor services for UC Davis Medical Center and all outlining clinics. A vendor will test, flush, and maintain records related to plumbed eyewash and emergency stations. The vendor will place a tag on the unit to document the test/flush was performed. Departments are responsible for ensuring their eyewash station is being tested monthly by the vendor by examining the tag for completion in the last 30 days. If tag is missing on the eyewash station, department must contact PO&M at (916) 734-2763.

Exception: CAP-accredited laboratories must continue to flush stations and maintain records on a weekly basis.

Eyewash Operation:

- In the event of an emergency, activate eyewash by pushing handle forward.
- Hold both eyelids open with thumb and forefingers. Roll eyeballs back and forth so fluid flows on all surfaces of eye and under eyelid.
- Flush eyes for 15 minutes.
- After equipment use, seek a medical advisor immediately for further treatment.

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Emergency Shower Operation:

- In the event of an emergency, activate drench shower by pulling on the pull rod.
- Begin to remove any clothing and shoes exposed to chemical or other hazardous substance (If eyes have been exposed to hazardous materials, follow procedure for eyewash operation)
- Flush eyes, face, and body for 15 minutes.
- After equipment use, seek a medical advisor immediately for further treatment.

Asbestos

To provide building occupants with basic information about asbestos containing materials commonly found in buildings.

What Is Asbestos?

The term asbestos refers to a family of naturally occurring minerals. These minerals have unique properties of chemical and fire resistance.

“Asbestos containing construction materials” are those manufactured construction materials that contain more than one-tenth of 1 percent asbestos by weight (Section 25195, Chapter 104, Division 20 of the State of California Health & Safety Code).

Materials that contain asbestos may be friable, meaning they can be easily crumbled with hand pressure.

Health Risks

The most common exposure to asbestos material is from breathing airborne fibers. When asbestos fibers are introduced into the respiratory system they can contribute to the development of:

- Asbestosis – a serious lung disease.
- Lung Cancer – the most common cancer associated with asbestos exposure.
- Mesothelioma – a rare cancer of the lining of the lung or abdominal cavities.

MINIMIZE EXPOSURE TO ASBESTOS FIBERS BY FOLLOWING PROPER WORK PRACTICES

Recognizing Asbestos Materials

Common types of materials that could contain asbestos:

- Sprayed on or toweled on fireproofing and soundproofing installed prior to 1980
- Boilers and pipes installed prior to 1980 are often insulated with asbestos materials
- Floor tiles in buildings constructed prior to 1985
- Roofing felts and sheeting
- Floor and roof mastics and sealants
- Gaskets

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Actions to Take

By taking the right action UC Davis Health workforce can reduce the risk of exposure to asbestos.

- Know where the asbestos is in the building and avoid disturbing it.
- If UC Davis Health workforce find materials that could contain asbestos, they should report them to their supervisor.
- UC Davis Health shall provide, at no cost to employees who perform housekeeping operations in areas which contains Asbestos Containing Construction Materials (ACCM), an asbestos awareness training course, which shall at a minimum contain the following elements: health effects of asbestos, locations of ACCM in the building/facility, recognition of ACCM damage and deterioration, requirements in the Cal OSHA standard relating to housekeeping, and proper response to fiber release episodes. Each such employee shall receive training annually.
- If UC Davis Health workforce see asbestos materials that have been disturbed, they should report the damage to their supervisor.
- If the maintenance of asbestos in the building is not being done properly, see that it is brought to the supervisor's attention.

Avoid Disturbing Asbestos Materials

- Avoid touching or disturbing suspect materials on walls, ceilings, pipes, or boilers. Asbestos fibers can be released when the material is disturbed.
- DO NOT drill holes in asbestos materials.
- DO NOT hang plants or anything else from ceiling covered with asbestos materials.
- DO NOT pin or hang pictures on walls covered with asbestos materials.
- DO NOT sand asbestos floor tiles or backing material.
- DO NOT damage asbestos materials while moving furniture, etc.
- DO NOT disturb asbestos material when replacing light bulbs, etc.
- DO NOT allow curtains, drapes, or dividers to damage asbestos materials.
- For asbestos information and assistance at UC Davis Health, call EH&S at (916) 734-2740.

Wildfire Smoke Protection

With the recent wildfire events in California, there have been episodes of increased wildfire smoke causing the air quality to become compromised, intermittently. The air quality is measured by local and state agencies with detectors in various locations and communicated daily on the internet – anyone with internet access can search for this information as it is free to the public. This measurement is called the Air Quality Index (AQI). The categories are broken down into 6 sections ranging from 'good' to 'hazardous' and ranging in color per category from green to maroon. This data is calculated using measurements of Particulate Matter (PM) 2.5 diameter micrometers (ultrafine particulate) in micrograms per cubic meter.

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<i>PM_{2.5} in micrograms per cubic meter</i>	<i>Air Quality Index Categories for PM_{2.5}</i>	
<i>0 to 12.0</i>	<i>0 to 50</i>	<i>Good</i>
<i>12.1 to 35.4</i>	<i>51 to 100</i>	<i>Moderate</i>
<i>35.5 to 55.4</i>	<i>101 to 150</i>	<i>Unhealthy for Sensitive Groups</i>
<i>55.5 to 150.4</i>	<i>151-200</i>	<i>Unhealthy</i>
<i>150.5 to 250.4</i>	<i>201 to 300</i>	<i>Very Unhealthy</i>
<i>250.5 to 500.4</i>	<i>301-500</i>	<i>Hazardous</i>

Two commonly used websites that can be visited to track the AQI at any time are:

- Airnow.gov
- Openmap.clarity.io

The University has measures in place to inform you of, and protect you from, the dangers of inhaling wildfire smoke, for example:

- Locate work in protected areas where air is filtered (enclosed buildings or vehicles)
- Change procedures (i.e. move workers to a place with lower current AQI for PM2.5 — learn more about how air quality indicators below)
- Reduce work time in areas with unfiltered air
- Increase rest time and frequency; provide rest area with filtered air
- Reduce the physical intensity of work to help lower breathing and heart rates

If you work outdoors or in an area with unfiltered air, you will receive additional training and information about how to remain safe during wildfire smoke events while at work. At AQI levels of 151 or greater for PM2.5, the University will take additional precautions to protect you from wildfire smoke. Contact your supervisor for questions about additional protections that may be available to you.

Fire Prevention Management

Campus Fire Marshal’s Office

The Campus Fire Marshal is designated by the State Fire Marshal to enforce the laws of the State of California. The Office is also responsible for providing fire and life safety services to the campus facilities as well as off-site clinics and office buildings associated with UC Davis Health.

Interim Life Safety Measures (ILSM)

The Office ensures ILSMs are developed for occupied buildings undergoing renovation or construction as required in the Life Safety Code. ILSMs ensure that an acceptable level of fire and life safety is maintained at all times. [See UC Davis Health Policy 1635](#)

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Teamwork

Teamwork is essential for patient fire safety. UC Davis Health workforce should know their department's fire and evacuation plan thoroughly. The fire and evacuation plan is a component of the disaster plan (Red Binder). If the fire is not within the surrounding area, 1) remain calm; 2) close patient doors, windows, and fire doors; and 3) ask visitors/patients to remain in their rooms.

Code Red

Code Red indicates a fire situation. When a Code Red is announced, ALL hospital staff members are expected to respond regardless of the location of the Code Red. Staff in affected areas must initiate their appropriate emergency response procedures. Staff in the unaffected areas should discuss internal procedures, review fire plans and prepare to receive relocated patients, staff or visitors who may have to leave an endangered area. See [UC Davis Health Policy 1606 Code Red Response](#).

Smoke Barriers

Smoke barrier walls separate each floor of the hospital into two or more smoke compartments. Smoke barriers are intended to create compartments to which building occupants can be safely and promptly relocated during a fire, thus preventing the need to have complete and immediate building evacuation. Doors in smoke barrier walls are identified with a small black and white sign located on the door that reads SMOKE BARRIER. Additionally, each departmental fire plan includes a floor plan showing each smoke barrier on the floor for which the fire plan is written. Each department should know the location of smoke barriers and plan relocating patients to them in the event of an emergency.

Fire Drills

UC Davis Health conducts fire drills once per shift per quarter in the hospital and ambulatory care clinics as well as annually in all freestanding buildings classified as a business occupancy. Staff participation in these drills is essential for an effective response during an actual fire. Fire Drills are not only required by The Joint Commission, they assist in training Hospital staff in "Fire Readiness" so that, in the event of an actual fire, the appropriate responses are known. All staff are required to participate in drills. UC Davis Health workforce should respond to a "Code Red Drill" announcement the same as an actual "Code Red" or fire. During each fire drill, all staff has a role to fulfill. Supervisors shall observe the reaction of staff, review procedures, and provide feedback to staff on response. See [UC Davis Health Policy 1652 Fire Drills](#).

Fire Emergency – R.A.C.E.

R.A.C.E. is the acronym used to assist staff in remembering what to do in the event of a fire emergency. The individual letters of the acronym stand for the following:

R is for Rescue --

Remove all persons from the danger area, including oneself

A is for Alarm --

Call 911 and activate the nearest fire alarm pull station. 911 calls initiated on UC Davis Health phones go to the UC Davis Dispatch Center.

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	UC Davis dispatchers are familiar with the UC Davis Health and will promptly notify the appropriate agencies. 911 calls initiated on cell phones go to the California Highway Patrol 911 dispatcher.
<i>C is for Confine --</i>	Confine the fire to the smallest area possible. Closing doors to the fire room/area is a very important and required task to prevent the fire from spreading.
<i>E is for Extinguish --</i>	UC Davis Health workforce should extinguish the fire only if the fire is the size of an office waste container or smaller and they are competent in the use of a fire extinguisher.

Classes of Fire

There are 3 basic classes of fire: A, B, and C.

- Class A fires involve ordinary combustibles (trash, paper, and wood).
- Class B fires involve flammables or combustible liquids (gas, oil, or grease).
- Class C fires involve energized electrical equipment (ECG, exam lamp, computer).

Use of Fire Extinguishers – P.A.S.S.

Remember to read the label on the extinguisher. UC Davis has different types of fire extinguishers. The dry chemical or “multi-purpose” fire extinguisher is the most common. The multi-purpose extinguisher can be used on all classes of fires (A, B, or C).

If the fire is small (no larger than an office size trash can), attempt to extinguish the fire; however, DO NOT PUT YOURSELF IN DANGER and always ensure there is an escape route. Once a fire starts, it could double in size every 30 seconds. An acronym utilized to assist UC Davis Health workforce in remembering how to operate a fire extinguisher is P.A.S.S. The individual letters of the acronym stand for the following:

<i>P is for Pull -</i>	Pull the pin located in the handle.
<i>A is for Aim -</i>	Aim the extinguisher at the base of the fire not at the smoke.
<i>S is for Squeeze -</i>	Squeeze the handle.
<i>S is for Sweep -</i>	Sweep the base of the fire. Start with the edge of the fire nearest to oneself, sweep from side to side until the fire is out or the extinguisher is empty.

Discharge the extinguisher six to eight feet at the base of the fire. If the fire continues to burn, do not search for another extinguisher. Confine the fire by closing doors and leave the area immediately.

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Medical Gas Shutoff Valves

Know the types of medical gases and the locations of all medical gas shutoff valves in one's area. The valve should be clearly labeled as to the areas/rooms they serve. Shutoff valves may not be blocked. If the valves are not labeled or incorrectly labeled, contact the Office at (916) 734-3036. Review [UC Davis Health Policy 1680 Emergency Shut-Off of Medical Oxygen in the Event of a Fire](#) for more information.

Building Evacuation

In the event of an alarm, some buildings and floors require evacuation instead of relocation. If this is the case for one's building or floor; proceed to lowest level of the building via the exit stairs. Do not attempt to use the elevators. Use handrails while descending. All emergency exits are clearly marked to properly guide everyone to the exterior of the building. From there, please proceed to the designated assembly area. Disabled individuals may be staged at the stair landing and need assistance with evacuation/descent. Assist, if able, or report the location of the individual to emergency personnel.

Alcohol-Based Hand-Rub Dispensers

Alcohol-based hand-rub dispensers include those that are mounted as well as free-standing liquid containers. When dispensers are mounted in a corridor, the corridor must have a minimum width of 6 feet. Dispensers cannot be installed within 6 inches horizontally of an ignition source (light switch, electrical outlet, etc.). Additional information can be located at UC Davis Health Fire Prevention Department at <https://health.ucdavis.edu/fire/pdfs/Alcohol-Based%20Hand-Rub%20Dispensers%205-2017.pdf>.

Medical Equipment Management

The Clinical Engineering Department is responsible for the repair, inspection, and maintenance of medical equipment throughout the UC Davis Health.

All medical equipment must be inspected and tagged by Clinical Engineering prior to initial clinical use regardless of how the equipment was acquired (e.g. demo, borrowed, rental, purchase, lease, etc.)

Clinical Engineering Information

For further information regarding medical equipment and/or Clinical Engineering services, call (916) 734-2846. Additional information is available by referring to the Clinical Engineering website (<http://cehelp.UCDMC.ucdavis.edu>) or the online UC Davis Health policy and procedure manuals.

Training

All medical equipment users are required to be able to properly operate medical equipment that is under their control. Periodic equipment training is required and is the department's responsibility. If there is a question about how to operate equipment, refer to the device's operator's manual on file in each department or ask one's immediate supervisor or department manager.

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Equipment Failure and Reporting

All equipment that is malfunctioning shall be taken out of service immediately. All equipment users are required to know where critical back up equipment is located and what procedures to follow when critical equipment fails. Broken equipment and/or equipment that is suspected to be out of calibration or otherwise not performing to its original specification must be reported to Clinical Engineering.

Equipment Caused Injury

As required by the FDA's Safe Medical Devices Act (SMDA), equipment that fails and causes or contributes to patient injury, patient illness or patient death is required to be formally reported to the FDA and the medical device manufacturer. At UC Davis Health, the reporting procedure is to complete an online Incident Report through Incident Reporting system, RL Solutions (RLDatix). See [UC Davis Health Policy 1466 Incident Reports](#). All equipment involved in the incident, including accessories and consumables must be sequestered and Clinical Engineering notified immediately.

Equipment Inspection

Before each use of any electrical device, inspect the power cord and plug for broken insulation, loose screws, or bent prongs. Special attention should be given to the point where the cord and plug join as well as the place where the cord enters the device.

Electric Safety

Water is a conductor of electricity.

DO NOT place liquids on top of electrical devices

DO NOT set equipment on wet areas.

DO NOT use equipment on which liquids have been spilled. Turn off or unplug equipment.

DO NOT touch electrical equipment with wet hands.

NO personally owned (staff, patients or visitors) line powered (including battery charger) electrical devices are allowed in patient care areas at UC Davis Health. This restriction includes coffeepots, radios, and TVs. All "loaned" devices must be inspected and tagged by Clinical Engineering as electrically safe. There is an exception for patient-owned, battery powered laptop computers that have grounded or double-insulated battery chargers.

NO adapters or two-pronged electrical devices shall be used at UC Davis Health. Two-pronged electrical devices are not grounded and their use in hospitals is a violation of California Code of Regulation, Title 22, and paragraph 70837(e). Labeled (e.g. UL), double-insulated equipment is allowed.

Avoid using extension cords. If it is absolutely necessary to use an extension cord, use only the yellow "hospital grade," three-wire, heavy-duty type of extension cord. Extension cords for non-patient care

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equipment may only be used as temporary wiring for portable hand tools, or while a permanent electrical service is being installed. In non-patient care areas, extension cords may be used to serve a short-term research experiment not exceeding six months. Surge protectors for computer equipment shall not be used as extension cords. Extension cords shall not be used as a substitute for fixed wiring. Do not use extension cords where subject to physical damage or hazardous locations (e.g., attached to buildings, walls, doors, windows, or under carpets).

Relocatable power taps (RPTs), also known as power strips, or plug strips, for use in patient care areas shall meet the following requirements: labeled by their manufacturer as hospital grade, mounted (e.g. on a rack, table, pedestal, or cart), have a total electrical current (amps), produce a draw of less than 75% of the RPT's listed capacity, and plugged directly into a wall outlet (i.e., not "daisy-chained").

Special Precautions for Electrically Sensitive Patients

Special precautions need to be taken for "electrically sensitive patients," e.g. patients with central pressure lines, patients with external pacemakers. Recognize that a very small amount of electrical current (less than a normal healthy person can feel) can cause cardiac fibrillation if applied directly to the heart. Possible routes to the heart include fluid filled catheters placed in or near the heart and external pacemaker wires that inadvertently come into electrical contact with an ungrounded or otherwise malfunctioning device. Electrically sensitive patients may commonly be found in critical care units, the cardiac catheterization laboratory, and the operating room.

Radiation

The Health Physics Office answers questions about radiation safety at (916) 734-3355. After hours, the UC Davis Health Radiation Safety Officer can be reached by paging (916) 816-5538.

Information is available on the intranet at: <http://intranet.UCDMC.ucdavis.edu/safety/hp/index.shtml>

Health Physics is responsible for overseeing the safe and effective use of ionizing radiation within the Health System. X-Ray machines and radioactive material are used at UC Davis Health and the Primary Care Network for diagnostic and therapeutic purposes, as well as in research and development. Title 17 of the California Administrative Code regulates the use of radiation. The University of California, Davis is issued a broad scope license that details the use conditions for all radioactive material at the University. The campus-wide Radiation Safety Committee and the Radiation Use Committee at UC Davis Health enforce these regulations. The [UC Davis Radiation Safety Manual](#) details the requirements for use of radiation producing machines and radioactive materials at UC Davis.

Radiation producing machines and radioactive materials at UC Davis Health are used under Radiation Use Authorizations (RUA) that are issued by the Health Physics Office to Department Managers and Principal Investigators. RUAs specify the conditions under which radioactive materials or radiation-producing machines may be used. All radioactive materials and radiation producing machines must be labeled with the radiation symbol. Periodic inspections are made to assure that this technology is being

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used in a safe and effective manner. Only personnel properly trained by the Health Physics Office or certified by the State of California should handle materials or devices labeled with the radiation symbol. These persons are considered Radiation Workers.

Human subject research protocols and consent forms, which involve use of ionizing radiation from machines or radioactive materials, must be approved by the Radiation Use Committee. Applications are available at the website above.

Only Health Physics staff is authorized to pick up and dispose of radioactive materials. If UC Davis Health workforce see a box with the yellow and purple or yellow and black international radiation symbol (the trefoil, shown below) on it and the box is in a location that UC Davis Health workforce do not think it should be, call Health Physics (916-734-3355).



Radiation producing machines and radioactive materials are used throughout the hospital and research areas. Signs, such as the trefoil or the words “Caution X-Ray” or “Caution Radioactive Material”, located at the entrance to the work area will identify the presence of hazardous materials in the workplace. The trefoil alerts UC Davis Health workforce so that they can minimize the potential exposure to radiation by following the established protocols. This includes limiting the time of the exposure, increasing the distance between oneself and the radiation source, using radiation shielding, and wearing personal protective equipment as necessary. Basic rules to follow include:

- Follow all room postings or instructions carefully.
- Ask the laboratory personnel to identify areas that should be avoided.
- Do not handle anything labeled with the radiation symbol (unless it is part of your job).
- Call the Health Physics Office (916-734-3355) for any questions or concerns.
- Leave the room locked when unoccupied.

Lead aprons must be worn in rooms when fluoroscopy is performed. Lead aprons are required to be inspected periodically to assure that they are in good condition. Refer to [UC Davis Health Policy 1728](#) for specific information about the care and handling of lead aprons. Staff are required to be trained and authorized to use radioactive material or radiation producing machines. The specific requirements that must be followed when operating radiography and fluoroscopy equipment are outlined in [UC Davis Health Policy 2717](#). Other than certain residents and fellows, all physicians who operate fluoroscopy equipment must possess a state-issued fluoroscopy supervisor and operator permit (CCR, Title 17, section 30463). Copies of permits must be kept on site and be available upon request.

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If UC Davis Health workforce are assigned a radiation dosimeter, they should wear it at all times and leave it at the workplace at the end of their shift so that it will not get lost or damaged. UC Davis Health workforce should not wear their dosimeter anywhere except while working at a UC Davis facility. If UC Davis Health workforce are badged by another facility, it is their responsibility to provide dosimeter reports to the Health Physics Office. If UC Davis Health workforce would like to have a dosimeter issued to them, contact the Health Physics Office. If UC Davis Health workforce become pregnant and work with or around radiation, they may contact the Health Physics Office at 916-734-3355 if they would like to arrange for fetal radiation monitoring.

“Notices to Employee” signs are posted in all areas where radiation or radioactive materials are used. It explains the employees’ responsibilities to know and understand California radiation protection standards and the employer’s operating and emergency procedures.

Remember, if staff work in an area where radiation is used, follow safety protocols and regulations. Contact the Health Physics Office if assistance is needed, if you are unsure of a protocol, or if an incident/accident has occurred.

The Health Physics Office is also available to answer technical questions concerning radiation applications in medicine and research, as well as to provide information about the biological effects of radiation exposure to employees and patients. Radiation safety in-services are available and can be requested by calling the Health Physics Office at 916-734-3355.

Medical Lasers

The Health Physics Office Laser Safety Officer answers questions about laser safety at 916-734-3355. After hours, the UC Davis Health Radiation Safety Officer can be reached by paging 916-816-5538.

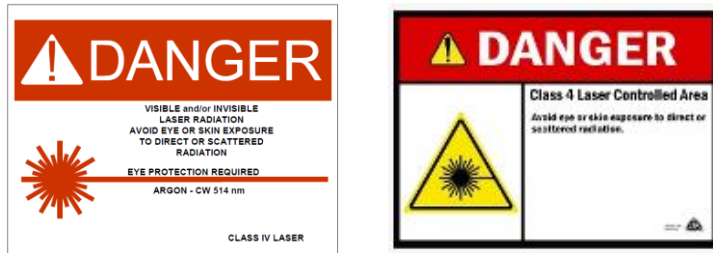
If UC Davis Health workforce work with medical lasers, they must receive medical laser safety training at either UC Davis Health or from another accredited source. Required training must be documented and records of training must be available upon request.

Guidelines for the safe use of lasers in medicine are found in ANSI Z136.1 “American National Standard for the Safe Use of Lasers” and ANSI Z136.3 “American National Standard for the Safe Use of Lasers in Healthcare.” Although these standards are not law, they are referenced by OSHA, Cal OSHA, and The Joint Commission as the standards by which laser safety programs should be administered.

Lasers are used at UC Davis Health for surgical, diagnostic, therapeutic and research purposes. All lasers must be used according to manufacturer specifications and according to a Safety Protocol or Standard Operating Procedure (SOP), [UC Davis Health Policy 1642](#), and the [UC Davis Health Medical Laser Safety Manual](#).

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Laser treatment rooms must be posted according to [UC Davis Health Policy 1642](#). The posting will be a sign similar to the ones shown below:



Never enter a room posted for laser use unless wearing the required laser safety eyewear. If there are any questions about laser safety precautions, ask the responsible clinician or Equipment Specialist. Please contact the Medical Laser Safety Officer at (916) 734-3355 if there are any questions or you would like to schedule a Medical Laser Safety in-service.

Magnetic Resonance Imaging (MRI)

Magnetic Resonance Imaging (MRI) uses magnetic fields, radio frequencies and a computer to produce images of the inside of the body. The magnetic fields are not known to be harmful and are painless. MRI is effective in visualizing soft tissue, the brain, the joints, and the musculoskeletal and vascular systems.

The MRI poses specific safety hazards in that any magnetic object (e.g. metal object) within the high magnetic field of the magnet will be pulled into the scanner and itself become a projectile. This could cause severe injuries to or even death of a patient or staff member as well as considerable damage to MRI equipment. To avoid a safety emergency, access to zones III and IV of the MRI suite is severely restricted. Screening of patients and staff is mandatory.

Hospital staff must be aware that the magnet is always on, and that the magnetic field cannot be seen or heard. The closer an object gets to the MRI, the stronger the magnetic force is (exponentially more). This force can pull metal objects into the machine at great speed and can cause severe injury or death. Metal objects, such as gurneys, oxygen tanks, infusion pumps, tools, and other patient-use items containing metal that are not labeled as MR safe, cannot enter the MRI environment. All personnel approaching the area must be aware of safety issues at all times. All staff and faculty who have a purpose to access MRI zone III or zone IV, such as a nurse, respiratory therapist, or environmental services are required to complete the online MRI Safety Training on an annual basis.

Hospital staff will need to consult with MRI Staff if a patient has an implanted device, such as a pacemaker, to determine if the device is MR conditional. For the safety of the patient, physicians ordering an MRI are required to provide accurate information regarding known implants, prosthetics, pacemakers, or any other metallic objects. Patients with implanted devices that are not deemed MR conditional cannot be imaged or even come into the MRI prep area as the magnetic field may disrupt the function of these devices, which could result in death. Mechanically ventilated patients require

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special ventilators, oxygen tanks, and monitoring devices that are MR conditional. The MRI technologist or physician can supply the floor with the necessary instructions for these high-risk patients. Other devices, such as prosthesis, pumps, surgical clips or metal fragments, will be screened to determine if they are MR conditional. Jewelry, hairpins, glasses, wigs, hearing aids, non-permanent dentures, etc., must be removed before entering zone III.

Some of the safety precautions are:

- Warning signs posted on doors.
- Obtaining sufficient information about possible implants a patient has. This information should be provided by the ordering physician.
- The use of hand-held magnet scanners to help detect metal objects.
- Being cleared by the MRI technologist
- Refer to the [UC Davis Health Policy 1727 Department of Radiology Magnetic Resonance Safety](#) for additional information. Any staff that enter controlled MRI spaces must complete periodic training in accordance with this policy.

Utility Systems Management

Plant Operations and Maintenance

Plant Operations and Maintenance (PO&M) is responsible for the repair, inspection, and maintenance of all utility systems throughout the UC Davis Health. If UC Davis Health workforce have any questions regarding utility systems, please call PO&M at (916) 734-2763.

PO&M is open 7 days a week, 24 hours a day for any electrical safety, equipment maintenance, or utility system problems. Routine service requests should be submitted online using the [PO&M Service Request System](#). Alternatively, type request in the browser's address bar. Urgent requests, requiring work to be accomplished on a STAT basis involving conditions where patients', visitors', or employees' lives or health are in danger, should be called to (916) 734-2763 or submitted online using the Service Request System. Some examples of what is considered to be an appropriate emergency request include, but are not limited to the following:

- | | |
|--|--|
| - Code blue alarm failure | - Code red alarm failure |
| - Medical gas/air problems | - Sterilizer problems /failures |
| - Patient call system failure | - Water, steam, gas, air, sewer system failure |
| - Emergency power generator failure | - Lighting directly related to patient care |
| - Roof leaks /plumbing failures | - Broken window /door glass |
| - Power failure /thermostat adjustment | - Flooding conditions |
| - Security lighting /alarm failure | - Door failure |
| - Elevators not operating correctly | |

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Training

All utility systems users are required to be able to properly use the utility systems under their control. Periodic training is required and is the department's responsibility. If there is a question about how to operate a utility system, refer to the operating instructions, the quick reference cards or ask one's immediate supervisor or department manager.

Utility System Failure and Reporting

All system malfunctions due to failure or improper use must be reported or, if authorized, taken out of service immediately. All utility system users are required to know how to notify PO&M of system problems and how to shut down the portion of the system under their control. The PO&M 24-hour notification number is (916) 734-2763. Some electrical outlets have a red cover, or the outlets themselves are red. These outlets are connected to emergency backup and provide power that will be uninterrupted, even if there is a loss of normal power. Red telephones provide back up for incoming and outgoing calls in case of a major failure of the normal telephone system.

Information

For further Information regarding utility systems or PO&M services, call (916) 734-2763.

Security Management

UC Davis Health personal safety and security is important. The heart of the Health System's Security Program is outlined in the Security Management Plan, which describes how the UC Davis Health and UC Davis Police Department manage the physical and personal security of patients, staff and visitors at UC Davis Health's facilities. The plan is reviewed and updated annually.

The Security web site is an excellent resource for up to date security information (http://intranet.UCDMC.ucdavis.edu/safety/security/security_welcome.shtml). UC Davis Health workforce can find the Security web site by typing safety in the address bar from the intranet and then click on "Security" on the left-hand side of the Environmental Health & Safety home page. On the Security home page, UC Davis Health workforce will find links to an overview of the security program, the UC Davis Police Department web site and the Health System's Workplace Violence and Hate Incidents site.

All telephone lines at the UC Davis Health campus are connected to the UC Davis dispatch center. UC Davis Health workforce can dial 9-1-1 from any landline on the Sacramento campus and be connected directly to the dispatch center. From a cell phone, call (916) 734-2555. UC Davis Health recommend that UC Davis Health workforce program this number into their cell phone. If UC Davis Health workforce dial 9-1-1 from a cell phone, the call is received by the California Highway Patrol and may result in a longer response time for assistance.

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Identification Badges and Cardkeys

UC Davis Health workforce must wear their photo identification badge at all times. Failure to do so may result in corrective or disciplinary action being taken in accordance with appropriate personnel policies or union contracts. Photo identification badges must be worn so that the photograph, name, working title and department are clearly visible. No modifications can be made to identification badges unless authorized by the organization.

Visitors to the Emergency Department are required to wear visitor badges at all times. Visitors to the rest of the hospital must obtain and wear a visitor badge after 9 pm. Access into the hospital is controlled after 9 pm; therefore, employees entering the hospital must show their badge to the Protective Service Officer, or PSO, at the visitor desk.

UC Davis Health employee's photo identification badge is attached to a cardkey. The majority of buildings require use of a cardkey to enter the building during non-business hours. Security sensitive areas have enhanced access control in place at all times and require the use of UC Davis Health employee's cardkey. These areas include cash handling areas, Emergency Department, infant and pediatric nursing units, research labs, and Pharmacy.

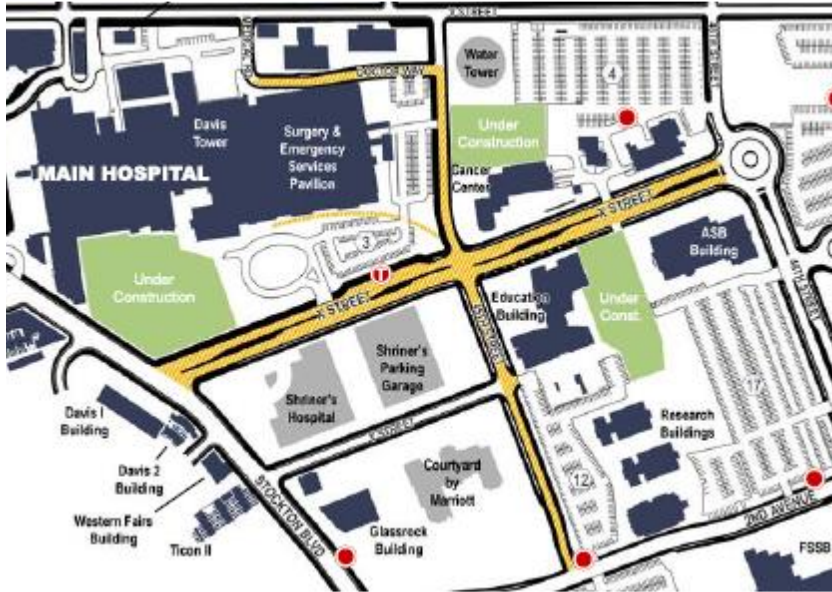
Personal Safety

UC Davis Health workforce can take several actions to enhance their personal safety. Put personal belongings, such as purse, wallet or laptop out of sight, preferably in a locked cabinet or drawer when at worksite; avoid leaving valuables in your vehicle. Be aware of surroundings when walking to and from one's car and use the shuttle service if staffs arrive or leave after dark. If possible, walk with others in a group. Avoid wearing headphones and texting when walking outdoors. Look ahead for advance warning should someone be acting suspicious and take evasive action, such as crossing the street – have phone preset to dial 911 quickly.

Parking and Transportation Services provide a shuttle service to and from outlying parking lots from 5:30 a.m. to midnight on a regular schedule. Protective Service Officers provide a safety escort service from midnight to 5:30 a.m. and 24 hours on weekends and holidays, upon request and when staffing levels and other calls-for-service allow. To obtain an after-hours safety escort, call the dispatch center at (916) 734-2555. The goal of these services is to provide UC Davis Health workforce with an alternative to walking alone on campus after dark. In addition, UC Davis Police Department conducts vehicle, foot bicycle and motorcycle patrols of the entire campus, including parking structures and parking lots.

Safety Corridor: the "Safety Corridor" is the preferred route to walk to the outlying parking lots as the "Safety Corridor" has additional lighting and emergency phones along the route. The "Safety Corridor" is highlighted in yellow in the map below. Employees are encouraged to avoid walking along Stockton Boulevard or V Street after dark.

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What Do I Do in an Emergency?

- Get everyone, including oneself, to safety as quickly as possible.
- Consider using a *Blue Tower* or other emergency telephone that provides a direct connection to UCDPD Dispatch is nearby and safer and/or faster to use for reporting the emergency.
- Call 911 via landline or (916) 734-2555 via cell phone and the dispatcher will direct callers to the police. If UC Davis Health workforce cannot stay on the line, if possible, keep a line open to police until they arrive. The more information the police receive, the more likely they can bring a potentially violent situation to a safe conclusion.

Training

All new staff, students, and researchers receive security familiarization during orientation sessions and as part of the annual refresher training. In addition, staff may receive in-service departmental-specific security training, such as for those who handle cash or have direct patient contact. The UC Davis Police Department and Security provides department-specific or hazard-specific security training, upon request. Available topics include active-threat defense, personal/professional safety, and conflict resolution.

Infant/Child Abduction (Code Rainbow)

Code Rainbow is the UC Davis Health designation for suspected infant/child abduction.

There are three major components to a successful infant/child abduction prevention program at UC Davis Health:

- Quick and timely execution of the appropriate response to abduction

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- Education of staff and patients/parents on proper prevention and response procedures
- Technological security measures

In the main UC Davis Health hospital facility, call the code line at 4-3666 to initiate a Code Rainbow. In external UC Davis Health facilities and Primary Care Network Clinics, call 911 to report child abduction. It is the responsibility of all employees to be aware of their department's response to a Code Rainbow. Read [UC Davis Health Policy 3304](#) and review Unit/Department specific responses to a Code Rainbow with one's Manager or resource person.

The policy outlines the following prevention/response procedures:

In the hospital, immediately dial 4-3666 to report abduction. The hospital operator will begin announcing overhead "Code Rainbow and the unit, location, patient sex and age" until more information is available.

For hospital-based clinics, immediately dial 4-3666 (Hospital Operator Code Line) and 4-2555 (UC Davis Police Department) simultaneously. The Hospital Operator will send out an Alpha group page for Code Rainbow to include the building name, floor, patient sex and age.

For Primary Care Network Sites, dial 911 to contact local police; as soon as possible, call the UC Davis Health Hospital Operator, who will initiate notification to UC Davis Police and Public Affairs Office

The staff making the call will be expected to provide the following information: unit/department where abduction occurred, name of child on ID bracelet, sex of the child, ethnic background, age of child, description of abductor, last known location of travel, and description of any staff personnel following the abductor.

Staff shall attempt to safely follow the abductor. If contact is made, do not physically restrain the abductor but request that the infant/child be released. If the abductor will not release the child, continue to follow until the police arrive or it is impossible to pursue. If threatened or fearful for personal safety, the pursuit should be discontinued. Be prepared to give police a complete, detailed description of the abductor, the exit used, direction of travel, vehicle and license number.

Immediately secure the patient's room or area where the abduction occurred and prevent all persons in the area at the time of the abduction from leaving until the police dismiss them.

All personnel available in other patient care areas will observe their respective corridors and stairwells for suspicious activity. Notify the police by telephoning 911 if they encounter a suspicious person.

All available staff in Patient Transport and Environmental Services Departments will respond to the building exits to assist in locating the child and abductor, until Code Rainbow is discontinued.

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When given the “All clear” by UC Davis Police, the operator will announce, “Code Rainbow all clear” three times in succession.

HUGS - Preventing Infant Abduction

UC Davis Health utilizes a new state-of-the-art electronic security system, called HUGS, that protects infants and children from the threat of abduction while in the hospital.

HUGS create a “safe area” where infants/children are monitored at all times. This is where infants/children are supposed to be.

The system generates alarms when an infant/child is removed from the safe area, when a tag has been tampered with, when the tag is not seen by the system for a period, or when certain other conditions occur.

Refer to [UC Davis Health Policy 3302](#).

Emergency Unlocking of Patient Bathrooms

Staff may open locked patient bathrooms in an emergency. Here are examples from the main hospital of several handle configurations, and how to open them (there may be other types in clinics). Submit a PO&M work order if extra override keys are needed.

TYPE 1. Handle with a slot – the slot may be oblong or square. Any object that fits and provides enough leverage to twist the slot will work to unlock the door. Keys work well for this; almost any key will fit the oblong slot and will work.



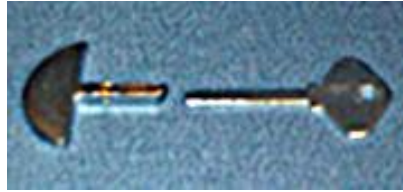
TYPE 2. Handle with knobs – can be turned using a hand.



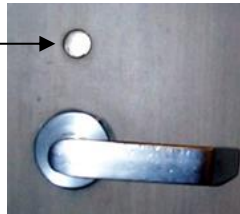
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TYPE 3. Square slot hidden behind metal cap. Remove cap with fingers. Then use square override key provided by PO&M (image below). Put key in slot and turn.

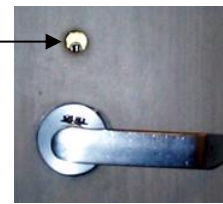
square override key



cap



cap removed to
reveal square slot



Online Incident Reporting

Incident Reporting system, RLDatix, is available for use by all UC Davis Health employees. It may be accessed directly from any UC Davis Health computer desktop. If the user types “incident” in the URL in Internet Explorer, it will take them directly to the login screen. The user ID and password correspond to the user’s Kerberos account.

[UC Davis Health Policy 1466 Incident Reports](#) outlines how the IR system is to be used. Any event that is “...not consistent with the routine Medical Center operations or situations that may potentially or actually result in unanticipated injury, harm or loss to any patient, visitor, student, volunteer, or employee” is to be reported. Essentially, anything that occurs outside the normal course of events should be reported. These would include adverse outcomes (e.g. pressure ulcers), procedural breakdowns (e.g., breach of confidentiality), and catastrophic events (e.g. wrong site surgery). The Incident Reporting system, RLDatix, has 27 forms within which an IR can be submitted.

It is also important to report near misses. Review of near-miss activity may promote system changes that will prevent actual adverse outcomes for patients and staff.

Use the Employee Event form for reporting only Safe Patient Handling Injury events. Do not use the Incident Reporting system, RLDatix, to report non-Safe Patient Handling Injury type of employee injuries (see [UC Davis Health Policy 2942 Workers Compensation Policy](#)), or exposures to blood borne pathogens or other employment related claims. Use the Workers’ Compensation system to report injuries and the online exposure reporting system for needle sticks and other blood borne pathogen exposures. However, UC Davis Health workforce may use the Incident Reporting system, RLDatix, to report the

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hazards that led to the injury or exposure. Make a note in the IR if a Workers' Compensation claim or exposure report has been filed. Questions regarding Incident Reporting system, RLDatix should be directed to Risk Management at 734-3883.

Reportable Events

UC Davis Health is required by state law to report specific adverse outcomes and certain privacy incidents that occur in the hospital to the California Department of Public Health (CDPH) no later than five days after the event is detected or, if the adverse event poses an ongoing, urgent or emergency threat to the welfare, health or safety of patients, personnel or visitors, within 24 hours of detection. Failure to do so may result in a fine of \$100 per day. Reports to CDPH involving adverse outcomes are made by Medical Staff Administration. Reports involving privacy incidents are made by the Compliance Department and/or the Privacy Officer.

For Adverse Outcomes, CDPH is required to conduct an onsite investigation within 48 hours (or two business days) of events that pose an ongoing threat of imminent danger of death or serious bodily harm.

The reportable events are described in [UC Davis Health Policy 1513 Reporting Serious Adverse Events and Provider-Preventable Conditions](#). Categories of reportable events, with some examples, include:

Surgical events: Surgery performed on the wrong body part, wrong patient, and wrong procedure.

Product or device events: Death or serious disability from use of contaminated drug or device.

Patient protection events: Infant discharged to the wrong person.

Care management events: Death or serious disability associated with a medication error.

Environmental events: Death or serious disability associated with electric shock.

Criminal events: Abduction of a patient of any age.

Or, catch all: Any adverse event or series of events that causes the death or serious disability of a patient, staff member, or visitor.

Workplace Violence and Hate Incidents

UC Davis Health is committed to preventing and responding to violence and hate incidents in the workplace through education, adherence to policy and swift action to threats and acts of violence. UC Davis Health's Violence and Hate Incidents in the Workplace Violence Policy ([UC Davis Health Policy 1616](#)) states that the UC Davis Health will not ignore, condone or tolerate disruptive, threatening, intimidating, violent, or hate incidents by or against any member of the University community or by any patient or visitor. Members of the University community engaging in such behavior will be subject to

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appropriate personnel action, up to and including termination or dismissal, as authorized by the applicable policy or collective bargaining agreement. The president of the University of California and the UC Davis chancellor have made it unequivocally clear that there is zero tolerance for any behavior that threatens personal safety, property and/or interferes with the mission of the University.

Workplace Violence

As defined by [UC Davis Health Policy 1616](#) "Violence and Hate Incidents in the Workplace Policy" includes both violence and disruptive or threatening acts that can lead to violence. The terms in P&P 1616 include:

Disruptive Behavior – aggressive behavior or conduct that may adversely affect the campus or workplace, may generate reasonable concern for personal safety, or may result in physical injury, including but not limited to the following:

Bullying – offensive or malicious behavior through persistent actions typically meant to undermine, intimidate or demean the recipient.

Domestic violence – abusive or violent behavior between individuals who have an ongoing or prior intimate relationship that is disruptive in the workplace.

Intimidation – behavior that is intended to frighten, coerce, or induce duress.

Property damage – intentional damage to property owned by the University, its employees, students, visitors or vendors.

Threat – expression of intent to cause physical or mental harm, which may be direct, indirect, conditional or veiled.

Violent behavior – unwanted physical contact such as hitting, kicking, pushing, shoving, throwing of objects, or the use of a weapon.

Hate Incident – any behavior or conduct that is disruptive, intimidating, threatening or violent, as defined above, and is committed against a person or their property because the person is, or is perceived to be, a member of a protected class (see UC Davis Personnel Policies for Staff Members [PPSM] 12 – Non-Discrimination in Employment). Hate incidents may include, but are not limited to, expressions of bias, graffiti/vandalism because a person is, or perceived to be, a member of a protected class).

Additionally, Cal/OSHA's Workplace Violence Prevention in Healthcare standard went into effect on April 1, 2017. The standard is found in the California Code of Regulations, Title 8, Section 3342.

The standard applies to work in the following healthcare facilities, service categories, and operations:

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Health facilities, as defined in subsection (b)

Home healthcare and home-based hospice

Emergency medical services and medical transport, including these services when provided by firefighters and other emergency responders

Drug treatment programs

Outpatient medical services to the incarcerated in correctional and detention settings

Pursuant to the law, the following protocols were implemented and are in-use:

Violent Incident Log

Recordkeeping

Workplace Violence Prevention Plan

Review of the Workplace Violence Prevention Plan

Training

Cal/OSHA specifically defines Workplace Violence as any act of violence or threat of violence that occurs at the work site. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:

The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;

An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;

Four workplace violence types:

- ***“Type 1 violence”*** means workplace violence committed by a person who has no legitimate business at the work site and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
- ***“Type 2 violence”*** means workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient.
- ***“Type 3 violence”*** means workplace violence against an employee by a present or former employee, supervisor, or manager.

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- **“Type 4 violence”** means workplace violence committed in the workplace by someone who does not work there but has or is known to have had a personal relationship with an employee.

For training resources, WPV Prevention Plan, and other information refer to the [UC Davis Health Violence in the Workplace website](#). UC Davis Health workforce may also contact the Workplace Violence Prevention Unit by telephone at (916) 734-2826 or by email at hr-reportviolence@ucdavis.edu with any questions or concerns.

Ways to Prevent Potential Violence in the Workplace

Evaluate each situation for potential violence when entering a room or beginning to relate to a patient or visitor. Be vigilant throughout the encounter. Do not isolate oneself with a potentially violent person. Always keep an open path for exiting. Do not let the potentially violent person stand between oneself and the door. The victim’s back should not be turned to the violent person. Stay two or three arm lengths away from the person. Never ignore concerning behaviors. If possible, have security and/or UCDPD officers present when interacting with a possible aggressive person. Promptly report and document incidents. Consult with UC Davis Police and Security

Ensure employees, students, patients and visitors are aware of and adhere to the Health System’s [UC Davis Health Policy 1616](#).

Utilize the Health System’s violence prevention resources including violence prevention classes, in-services, and other support services and departments identified below under resources

[UC Davis Health Policy 4067](#) “Management of a Violent Patient” provides specific procedures for patient care areas.

Aggression and violence predicting factors

Persons with a history of violent behavior

Forensic patients (prisoners)

Early release of acute and chronically mentally ill patients

Patient refuses psychiatric medication or hospitalization

Characteristics of aggressive and violent patients and victims

Verbally expressed anger and frustration

Body language such as threatening gestures

Signs of drug or alcohol use

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Presence of a weapon

De-Escalation Techniques - Verbal and physical maneuvers to defuse and avoid violent behavior

Respond quietly and calmly.

Do not take the behavior personally – remain calm and professional. Don't overreact.

Demonstrate respect and concern.

Consider offering an apology, even if nothing was done wrong.

Summarize the individual saying and make sure to communicate clearly.

Focus on areas of agreement to help resolve the concern.

Use the person's name.

Listen to the person's concerns and acknowledge the person's feelings.

Ask open questions.

Consider having UC Davis Police and/or security near-by to lessen response time.

Assault Cycle

There are five phases in the "assault cycle".

Trigger Phase: Factors that can make people angry and may trigger a violent response include lack of respect, not being listened to, loss of control, sense of injustice, feeling of discrimination, or a lack of competence in others.

Break the assault cycle by using de-escalation techniques described above.

Escalation Phase: Person experiences physiological "fight or flight" response, which includes increased heart rate, tenseness of muscles, blood rushing to head, sweating, and dryness in the mouth.

Continue use of de-escalation techniques.

Avoid actions that can escalate the situation, such as asking too many questions, being too rushed, or patronizing the person.

Crisis Phase: Both parties are aroused and assault is imminent or occurring

Reasoning with person is no longer possible.

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Manage one's own physiological and physical responses with an emphasis on safety of all involved, such as escape or leave the area, use of barriers, use alarms or shout to summon help.

Recovery Phase: Person is calming down.

Be aware of the potential for "flare up" and do not attempt an exploration of the incident at this phase.

Post crisis Phase: Person is low in mood, remorseful, guilty, ashamed, or despairing.

Resources available to employees for coping with incidents of violence.

- University Police 734-2555
- Employee and Labor Relations 734-3362
- Risk Management 734-3883
- Academic and Staff Assistance Program (ASAP) 734-2727
- Equal Opportunity-Sexual Harassment Program 734-5335
- Campus Violence Prevention Program (CVPP) – through the UC Davis Police Department (530) 752-1230
- The [UC Davis Health Violence in the Workplace website](#)
- For training resources and information, refer to the [UC Davis Health Violence in the Workplace website](#).

Reporting Criminal, Security, Workplace Violence, and Hate Incidents

In the event of an emergency or imminent danger, dial 911 via landline or (916) 734-2555 via cell phone or landline.

Criminal events are reported to the UC Davis Police Department by dialing 911 via landline or (916) 734-2555 via cell phone or landline to report crimes and in-progress activities that require police response; UC Davis Health workforce should be prepared to provide all available information to the dispatcher. The police department conducts criminal investigations and advises UC Davis Health personnel on crime prevention strategies. Incidents concerning suspicious people or circumstances are also reported to the police for investigation.

Mandatory Reporting of Workplace Violence

California regulations require mandatory reporting for certain workplace violence incidents. Any act of assault or battery against any on-duty hospital personnel that results in injury or involves the use of a firearm or other dangerous weapon shall be reported to the UC Davis Police Department immediately by dialing 911 via landline or (916) 734-2555 via cell phone. Any act of violence (physical assault or threat of physical assault) against "community healthcare worker" (home health worker) shall be reported to UC Davis Police Department immediately.

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Workplace violence incidents must also be reported as described in Health System's [Workplace Violence Reporting System](#). A report made via the [Workplace Violence Reporting System](#) is not a police report. Employees must contact the UC Davis Police Department to report an emergency and/or to file a police report by dialing 911 via landline or (916) 734-2555 via cell phone. The [Workplace Violence Reporting System](#), may be accessed via the UC Davis Health's Intranet by typing the word violence in the address bar. The Workplace Violence Prevention Unit can also be contacted via email at any time at hs-reportviolence@ucdavis.edu with any questions or concerns.

Hate Incident Reporting

The UC System wide Campus Climate Reporting System allows anonymous and identified reports of intolerance such as: Expressions of Bias Incidents, Hate Speech, Hate Crimes, Graffiti/Vandalism, Intimidation, Bullying or Physical Violence, Bias Incidents, Hostile Climate and other climate issues. The UC System wide reporting is available at the following website: [UC Davis Policy 1466](#).

Security incidents are reported via the Incident Reporting System as described in the [UC Davis Policy 1466](#), "Confidential Incident Report". Security-related Incident Reports are reviewed by the UC Davis Police Department to determine if an investigation is necessary. If a determination is made that an investigation is needed, the UC Davis Police Department is responsible for conducting the investigation and disposition.

To report threatening or violent behavior:

1. Immediately call the UC Davis Police Department.
2. Dial 911 from a landline
3. Dial (916) 734-2555 from UC Davis Health employee's cell phone or landline.
4. Immediately notify one's supervisor or manager about the situation.
5. Notify the Workplace Violence Prevention Unit as soon as possible: (916) 734-2826
6. On the same day of the incident, document the incident by reporting it online using Incident Reporting system, RL Solutions/RLDatix (Safety/Security/Workplace Violence).

Weapons on UC Davis Health Property

It is a serious violation of the law and against UC Davis Health policy and procedure to possess weapons on UC Davis Health property unless the UC Davis Health workforce is a sworn peace officer.

The California Penal Code makes it a felony to bring or possess the following items on the grounds or within buildings of the University of California:

A firearm; or

Any dirk (a dagger), ice pick, or knife having a fixed blade longer than 2-2½ inches; or.

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Other items that can inflict great bodily harm, such as BB gun, flare gun, slingshot, or bow/crossbow.

Possession includes, but is not limited to, possession of the aforementioned weapons on the person or in a vehicle.

Active Shooter/Threat

The United States Department of Homeland Security defines the active shooter/threat as "an individual actively engaged in killing or attempting to kill people in a confined and populated area"; an individual who is engaging in behavior that fits this definition typically uses a firearms(s) or other weapon, such as a knife, and there is no pattern or method to their selection of victims.

If there is an Active threat in the area, the phrase to remember is RUN, HIDE, and FIGHT. Plan ahead now and look around one's work area to identify an escape route. If RUNNING is not possible, identify one or more places to lock or block the entry in order to HIDE. As a last resort in a life or death situation, FIGHT in an attempt to incapacitate the active shooter.

If UC Davis Health workforce work with patients and are not in the area affected by the Active threat, identify how to lock or barricade all perimeter doors to HIDE; collectively guide others to safety. Hide out of view, set all noise-making communication devices to silent with no vibration, and turn off the lights.

The presence of an Active threat will be announced in plain English. The notification will state, "Active Shooter (or threat if known). Shooting (or other described violent action) in Progress. << announce location>>. Lockdown. This is not a drill." Depending on the location, the notification will go out via the overhead paging system in the hospital, via text pager in the clinics, or via WarnMe in the other buildings.

If UC Davis Health workforce encounter the threat, call 911 when it is safe to do so. If UC Davis Health workforce cannot speak, dial the number and set the phone down. If UC Davis Health workforce is not in immediate danger, answer the questions to provide the following information: location, number of shooters (or armed threat), physical description, number and type of weapons, and number of victims and hostages, if applicable.

When the UC Davis Police or other law enforcement officers arrive, follow the officers' instructions. Keep one's hands visible at all times. Avoid making quick movements toward officers such as attempting to hold on to them for safety. Avoid pointing, screaming and/or yelling.

The UC Davis Health "Active Shooter/Threat Response" ([UC Davis Health Policy 1632](#)) describes the expected response in more detail. In addition, a 5-minute video, called "Run. Hide. Fight. Surviving an Active Shooter Event", was developed by the Department of Homeland Security. It is available on

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YouTube. The training video is intense and depicts a simulated active shooter event.

<http://www.youtube.com/watch?v=5VcSwejU2D0>

A new video, called “Surviving an Active Shooter in a Healthcare Environment” addresses active shooter response in a patient care environment. Employees in inpatient and outpatient areas should view this 10-minutes video: <https://vimeo.com/123020803>.

Harassment & Discrimination Assistance and Prevention Program

UC Davis Health supports the University's commitment to a harassment and discrimination-free work and learning environment. HDAPP assists individuals and campus units to resolve conflicts and complaints related to all forms of prohibited harassment and discrimination, including sexual harassment and sexual violence.

To discuss a discrimination or harassment concern, please contact or visit the office:

2730 Stockton Blvd - Ticon III, Room 2200
916.734-3417 or 530.747-3864

Anonymous Call Line: 734-2255 **Website:** <http://hdapp.ucdavis.edu/>

To maintain privacy, UC Davis Health employees may use the Anonymous Call Line to discuss specific concerns related to harassment and discrimination.

Action Required

Any University employee who is not a Confidential Resource and who receives, in the course of employment, information that a student (undergraduate, graduate, or professional) has experienced sexual violence, sexual harassment, or other prohibited behaviors shall promptly notify the Title IX Officer or HDAPP.

Supervisors have a broader responsibility and must report all complaints or matters involving prohibited conduct, including discrimination, by contacting HDAPP at (916) 734-3417 or the Title IX Officer at (530) 752-9466.

Confidential Resources

Academic and Staff Assistance Program (ASAP)

916.734-2727 or 530.752-2727 <https://www.hr.ucdavis.edu/departments/asap>

Office of the Ombuds

530.754-7233 <http://ombuds.ucdavis.edu/>

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Center for Advocacy, Resources and Education (CARE)

530.752-3299 <http://care.ucdavis.edu/>

Services offered at UC Davis and Sacramento Campuses

Additional Resources

Sexual Violence <http://sexualviolence.ucdavis.edu/>

Harassment & Discrimination <http://hdapp.ucdavis.edu/>

Hate and Bias <http://reportheateandbias.ucdavis.edu/>

Sexual Harassment

University policy prohibits sexual harassment and sexual violence. Detailed information related to the University's policy can be found in [UC Davis Health Policy 400-20 Sexual Violence and Sexual Harassment](#), the University of California Davis policy, and the [UC Office of the President Policy on Sexual Violence and Sexual Harassment](#). Sexual harassment includes unwelcome behavior of a sexual nature when submission to sexual conduct is "required" for grades, jobs, medical treatment, or other aspects of University programs (quid pro quo) or when the conduct is sufficiently severe or pervasive that it unreasonably denies, adversely limits, or interferes with work or learning (hostile work environment) and creates an intimidating or offensive educational or employment environment. The conduct may be verbal, physical, and/or visual (photos, text messages, tweets, or bystander).

Prohibited sexual violence includes stalking, relationship violence, and/or sexual assault. Stalking is defined as repeated conduct directed at a person that would cause a reasonable person to fear for their (or others') safety. Relationship violence is defined as conduct by a romantic or intimate partner that intentionally or recklessly causes bodily injury to the person or places the person in reasonable fear of serious bodily injury. Sexual assault is defined as any non-consensual sexual contact, including penetration or intimate touching. The policy defines consent as affirmative (yes mean yes), conscious, voluntary, and revocable. If a person is incapacitated (impaired by alcohol or drugs, sleeping, passed out, etc.) to the point where decision making is affected, that person cannot be deemed to have consented. Stalking, relationship violence, and sexual assault are not only prohibited by UCD policy, they are prohibited by law.

In addition to refraining from engaging in the prohibited behavior listed above, employees may have reporting obligations if they witness sexual harassment/sexual violence or if someone makes them aware of any such behaviors. If a student complains that they have been sexually harassed or experienced any sexual violence, all employees (including student employees) are required to report. For concerns regarding sexual harassment or sexual violence experienced by employees or patients, the following are required to report: Campus Police; Human Resource Administrators; Academic Personnel administrators; managers and supervisors including Deans, Department Chairs,

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Directors of Organized Research Units and other academic appointees with managerial responsibilities; and Faculty members. Reports should be made to the Title IX Officer, Wendi Delmendo [(530) 752-9466; wjdelmendo@ucdavis.edu] or to the Harassment & Discrimination Assistance and Prevention Program (HDAPP): <https://hdapp.ucdavis.edu/>; (916) 734-3417).

In addition to reporting, responsible employees (anyone required to report as described above) are expected to consult immediately with Title IX/HDAPP and work in conjunction with Title IX/HDAPP to address the concerns raised. Responsible employees should not conduct their own investigation into concerns unless directed to do so by Title IX/HDAPP.

For more information about HDAPP, the policies, and resources for complainants or respondents, please visit <https://hdapp.ucdavis.edu/> and <https://sexualviolence.ucdavis.edu/>.

Also, please know that all employees are required to receive sexual harassment and sexual violence prevention education every two years. For more information, please visit Training and Development's website at <http://www.UCDMC.ucdavis.edu/hr/training/index.html>; or Staff Development and Professional Services' website at <http://sdps.ucdavis.edu/>.

Ergonomics, Body Mechanics, and Safe Patient Handling

The use of proper body mechanics, ergonomics, and safe patient handling principles assist staff in working safely and efficiently. Positioning the body safely requires awareness of one's posture to prevent risk of injury. Using the body safely means not exerting beyond one's physical limits. It is the responsibility of each employee to understand their personal limits and to know and use the resources available for assistance. Using the body efficiently requires possessing and maintaining a baseline fitness level necessary to perform job duties in a way that reduces the possibility of injury. Combining overall fitness, consistent practice of good body mechanics, the use of training and equipment, and the awareness of one's posture will lead to an increase in safety and satisfaction at work.

Body Mechanics

According to the U.S. Bureau of Labor Statistics, U.S. Department of Labor, in 2018, hospitals had the second highest incident rate and number of nonfatal occupational injuries and illnesses per select state government industries. Per the UC Risk Services Data Management System (RDMS), physical movement and patient handling were the two highest cause for employee work-related injuries in fiscal year 2019.

Knowing how to position and use one's body to actively and efficiently adapt to the work environment is known as practicing good body mechanics. The UC Davis Health workforce is encouraged to practice good body mechanics during and outside of work. Consider these tips related to lifting:

- Give oneself a wide base of support by spreading the feet at least shoulder-width apart, if not wider for an increase in stability and mobility.

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- Get close to the load. Loads further from the body create an increase in stress to the back.
- Place the hands in the best position to carry the load. The handles may or may not be in the ideal place. Grasp the item so that the larger muscles of the arm receive the majority of weight requiring less effort for the small muscles of the hand work less (e.g. compare hands flat on the sides of a box versus laying a box on the forearm and grasping the far edge).
- Test the weight before lifting. Shift, push, or tip the object to get an idea about its weight. Know personal physical limits, and request assistance when needed, e.g. team lift, mechanical assist.
- Direct the body toward the load. Nose and toes should align the same direction to prevent twisting. When changing direction while carrying a load, take a step or pivot on the balls of the feet.
- When rising with a load, lift upward using the large muscles of the hips and legs. Keep feet flat on the floor, back straight, and to assist in maintaining a neutral posture, look up or keep the bottom of the chin aligned parallel to the floor.
- Plan ahead; identify the final destination, prepare a clear path, and remove barriers.
- Lower load with control and maintaining a neutral posture. Remain focused throughout the entire lift.
- Staff should support and maintain a neutral posture throughout the day.

Maintaining physical fitness and a healthy lifestyle prevents injuries. If a job requires physical tasks, the UC Davis Health workforce should take responsibility for maintaining the strength, flexibility, and endurance required to complete those tasks. If the job is consistently sedentary, staff should take responsibility for maintaining a healthy diet and active lifestyle to provide balance. Physical fitness and wellness can start at work and staff should consider planning breaks accordingly. See the table below for examples of actions to take during breaks:

Activity (Relative Long Duration)	Break Ideas/Recommendations
Standing	Prop feet up
Monitor Viewing	Outdoor Walk
	Rehydrate
	Stare at another item approximately 20' away for 20 seconds
Sitting	Stand up & stretch or active exercise

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If assistance is needed for training, please contact the UC Davis Health Ergonomics Unit at 916-734-8840 or email hs-requestergonomics@ucdavis.edu.

For additional guidance on physical fitness and wellness, contact the UC Davis Health Wellness programs ([Living Fit Forever](#)) or Human Resources ([Work Life Balance](#)).

Ergonomic Self-Evaluation

The practice of maintaining proper body mechanics and using correct lifting techniques is important in preventing injuries. Body mechanics maintenance includes supporting neutral postures while operating a computer while either sitting or standing. Learn how to adjust your workstation monitor, keyboard/mouse, and chair with the Ergonomic Self-Evaluation tool.

The courses, Healthy Working: Ergonomics, course code DAHS-ERGO-ECO, and Healthy Working @ Home for remote workstations, course code DAHS-HWAH, are both located in on UC Learning. The self-evaluation questionnaires are intended to provide the UC Davis Health workforce with education about ergonomic principles and to increase comfort while working.

The self-evaluation should be completed and shared with one's supervisor to assure appropriate adjustments are made to the workstation. In cases where additional assistance is, please contact the UC Davis Health Ergonomics Unit at (916) 734-8840 or email hs-requestergonomics@ucdavis.edu. To request a reasonable accommodation, contact the Disability Management Services.

Safe Patient Handling

Every year, thousands of hospital workers are injured while performing patient handling tasks. Cal/OSHA requires hospitals in California to create and maintain a plan to protect health care workers from back and musculoskeletal injuries while also protecting patients. This plan must include a safe patient handling policy to use a powered patient transfer device, lifting device, friction reducing device, or a lift team, as appropriate, rather than lifting and/or transferring a patient manually.

Safe Patient Handling applies to all patient care units that are part of a general acute care hospital in California. The regulation identifies four types of patient handling:

To lift is to move a patient's body vertically or support part or all of the patient's body.

To mobilize is to put or assist in putting into motion part or all of a patient's body.

To reposition is to change a patient's position on a bed, gurney, chair, or other support surface.

To transfer is to move a patient from one surface to another, such as from a bed to a gurney.

Several types of equipment are available to assist with various patient handling tasks. Patient-lifts help the most immobile patients, with slings sized small to XXL (90-1,000 lbs.). UC Davis Health has portable

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lifts, with varying weight capacities (350-1,000 lbs.). These lifts come with special features, which include but are not limited to, the ability to assist a patient from their vehicle, or to assist with standing and/or walking. Additional devices available include the Hover Matt system, Prevalon Turn & Position, and Sally Tube reduced-friction transfer sheet. All are designed for single patient use (allowing repeated use for the same patient during their hospital stay) and have both a standard and bariatric version. Innovative technology is driving this emerging group of products. UC Davis Health is committed to evaluating new products prior to integration into the safe patient handling program.

Selection of the appropriate patient handling methods and equipment shall be determined by the registered nurse (RN) in conjunction with the Lift Team and/or licensed personnel prior to the patient movement. The RN shall be responsible for the observation and direction of patient lifts or mobilization and shall participate as needed in patient handling in accordance with their job description and use of the [Banner Mobility Assessment Tool \(BMAT\)](#).

Safe Patient Handling Resources

Safe Patient Handling information, including the Banner Mobility Assessment Tool (BMAT) and additional resources are located on the Lift Team webpage located at: <http://intranet.UCDMC.ucdavis.edu/pcs/liftteam/index.shtml>.

Review UC Davis Health Policy 4004, Safe Patient Handling, in full [here](#). Maintaining Your Physical Fitness and Wellness

Patient Safety

Patient Rights

The staff and medical staff at UC Davis Health shall observe the rights and responsibilities of patients and/or the authorized representative responsible for making medical decisions on behalf of the patient.

A notice summarizing patient rights and responsibilities shall be distributed to the patient and/or their authorized representative upon admission or as soon thereafter as reasonably practicable via the “New Patient Welcome Brochure.”

A list of patient rights will be appropriately posted within UC Davis Health facilities in English and in Spanish and include short statements (taglines) written in the top 15 languages spoken in California that indicate the availability of language assistance services free of charge.

The “Speak Up” initiative is a campaign launched by The Joint Commission, together with the Centers for Medicare and Medicaid Services, to encourage patients’ active involvement in their own care as a patient safety strategy. Information about the “Speak Up” initiative is included in the “New Patient

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Welcome Brochure” and is available upon request in Spanish, Chinese, Vietnamese, Hmong and Russian. An example of the “Speak Up” information is Attachment 7.

All patients will be provided a copy of the UC Davis Health Notice of Privacy Practices. For additional information on patient rights, refer to [UC Davis Health Policy 1402](#).

Homeless Patient Discharge Policy

Purpose of the policy:

The policy’s purpose is to help prepare patients who are experiencing homelessness for return to the community by connecting them with available community resources, treatment, shelter and other supportive services.

A “homeless patient” is defined in state law as an individual who:

Lacks a fixed and regular nighttime residence, or

Has a primary nighttime residence that is a supervised publicly – or privately-operated shelter designed to provide temporary living accommodations, or

Is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.

Which hospitals must comply?

The homeless patient discharge law applies to general acute care hospitals (like UC Davis Medical Center), acute psychiatric hospitals and special hospitals.

When does the law take effect?

Most provisions of the homeless discharge planning law took effect on January 1, 2019 and the requirements to have a written plan to coordinate with community partners and maintain a homeless patient log took effect July 1, 2019.

Which patients are covered?

This policy applies to hospital inpatients and emergency department patients, but not to patients with an outpatient clinic or physician office visit. The homeless patient discharge planning law must be followed whenever a hospital discharges any homeless patient, unless they are transferred to another licensed health facility, such as a hospital, skilled nursing facility, intermediate care facility, licensed board and care facility, psychiatric facility, etc.

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What is required?

1. Ask about housing status: hospitals must inquire about a patient's housing status during the discharge planning process.
2. Cultural competency: the policy must require that information about discharge or transfer be provided to all patients experiencing homelessness in a culturally competent manner and in a language that they understand.
3. Nondiscrimination: housing status must not be used to discriminate against a patient or prevent medically necessary care or hospital admission.
4. Individual discharge plan: the hospital homeless discharge planning policy must require an individual discharge plan for patients who are experiencing homelessness that helps prepare the patient for return to the community by connecting them with available community resources, treatment, shelter, and other supportive services. The homeless discharge plan must be guided by the best interest of the patient, their physical and mental condition, and the patient's preference for placement. Patients experiencing homelessness must be informed of available placement options.
5. Unless the patient who is experiencing homelessness is being transferred to another licensed facility, the policy requires the hospital to identify a post-discharge destination for the homeless patient as follows, with priority given to identifying a sheltered destination with supportive services:
 - a) A social services agency, nonprofit social services provider, or governmental service provider that has agreed to accept the patient, if they are agreeable to the placement. The hospital shall provide potential receiving agencies or providers written or electronic information about the patient's known post-hospital health and behavioral health care needs and shall document the name of the person at the agency or provider who agreed to accept the homeless patient.
 - b) The patient's residence. In the case of a patient who is experiencing homelessness, "residence" for the purposes of this subparagraph means the location identified to the hospital by the patient as their principal dwelling place.
 - c) An alternative destination, as indicated by the patient. The hospital shall document the destination indicated by the patient or their representative.
6. The hospital shall document all of the following prior to discharging patients who are experiencing homelessness:
 - a) Medical screening and evaluation: the treating physician shall provide a medical screening examination and evaluation to determine the patient's clinical stability for discharge,

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- including, but not limited to, an assessment as to whether the patient is alert and oriented to person, place, and time, and the physician or designees has communicated post-discharge medical needs to the patient.
- b) Follow-up care: if medically necessary, the patient has been referred to a source for follow-up care.
 - c) Prescriptions: the law requires that the homeless patient be provided with a prescription(s), if needed. If the hospital has an onsite pharmacy licensed and staffed to dispense outpatient medication, an appropriate supply of all necessary medication, if available, must be provided to the patient — that is, the actual medication(s), not just a written prescription(s). In addition, each patient must receive discharge medication counseling.
 - d) Infectious disease screening: the hospital must do one of the following: 1) Offer the homeless patient screening for infectious disease common to the region, as determined by the local health department; or 2) Refer the patient to another location (perhaps a county clinic) for such screening.
 - e) Vaccinations: homeless patients must be offered vaccinations appropriate to their presenting medical condition. The treating physician should try to determine the patient's vaccination status and which vaccination(s) are appropriate to the patient's presenting medical condition.
 - f) The treating physician has provided a medical screening examination and evaluation. If the treating physician determines that the results of the medical screening examination and evaluation indicate that follow-up behavioral health care is needed, the patient shall be treated or referred to an appropriate provider. The hospital shall make a good faith effort to contact one of the following, if applicable:
 - i) The homeless patient's health plan, if the homeless patient is enrolled in a health plan.
 - ii) The homeless patient's primary care provider, if the patient has identified one.
 - iii) Another appropriate provider, including, but not limited to, the coordinated entry system.
 - g) Patients who are experiencing homelessness must be screened for, and provided assistance to enroll in, any affordable health insurance coverage for which he or she is eligible.
 - h) Transportation: the hospital must offer the homeless patient transportation to their post-discharge destination, if that destination is within 30 minutes or 30 miles of the hospital.

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- The hospital may offer transportation to a more distant destination if it wishes to do so but is not required to. The patient may refuse offered transportation.
7. A hospital shall develop a written plan for coordinating services and referrals for patients who are experiencing homelessness with the county behavioral health agency, health care and social services agencies in the region, health care providers, and nonprofit social services providers, as available, to assist with ensuring appropriate patient discharge. The plan shall be updated annually and shall include all of the following:
 - a) A list of local homeless shelters, including their hours of operation, admission procedures and requirements, client population served, and general scope of medical and behavioral health services available.
 - b) The hospital's procedures for homeless patient discharge referrals to shelter, medical care, and behavioral health care.
 - c) The contact information for the homeless shelter's intake coordinator.
 - d) Training protocols for discharge planning staff.
 8. Each hospital shall maintain a log of all patient's identified as homeless discharged and the destinations to which they were released after discharge. The hospital shall maintain evidence of completion of the homeless patient discharge protocol in the log or in the patient's medical record.

Legislation:

https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1152

California Hospital Association:

https://www.calhospital.org/sites/main/files/file-attachments/discharge_planning_book_-_members.pdf

[UC Davis Health Policy 4089 – Discharge Plan](#)

Ligature Risk and Self-Harm

General Acute Care Hospitals and non-behavioral health units DESIGNATED for the treatment of psychiatric patients (i.e., Emergency Departments or Medical Units) are required to establish and maintain a safe, functional environment. The Joint Commission "Environment of Care" Standard [EC 02.06.01](#) states "Interior spaces meet the needs of the patient population and are safe and suitable to

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the care, treatment, and services provided.” Therefore, ligature and self-harm risks must be identified and eliminated when possible. Policies and procedures must be developed by healthcare facilities and implemented to mitigate the harm posed by such risks. Mitigation plans must include, at a minimum, the following:

- Ensuring that leadership and staff are aware of the current environmental risks
- Identifying patients’ risk for suicide or self-harm, then implementing appropriate interventions based upon risk
- Assessing and re-assessing at-risk behavior as defined by the organization
- Ensuring the training of staff to properly identify patients’ level of risk and implement appropriate interventions
- Incorporating suicide risk and self-harm reduction strategies into the overall Quality Assessment/Performance Improvement (QAPI) program
- If equipment poses a risk but is necessary for the safe treatment of psychiatric patients (i.e., medical beds with side rails on a geriatric unit), the organization must consider these risks in patients’ overall suicide/self-harm risk assessments, then implement appropriate interventions to diminish those risks

All physical risks not required for the treatment of the patient that can be removed, must be removed. Furthermore, an appropriate level of effective surveillance must be implemented if self-harm risks remain in the environment. Organizational policies and procedures must adequately guide staff in the assessment of patients’ risk for suicide/self-harm and the implementation of interventions based upon the patients’ individual needs.

UC Davis Health has implemented tools, policy, and protocols to support the maintenance of a safe and functional environment for our patients. Review the following policy and attachments:

[UC Davis Health policy 4016 Identification and Management of Patients at Risk for Suicide](#)

[UC Davis Health Policy 4016 \(Attachment 4\) Environmental Patient Safety Sweep](#)

[UC Davis Health Policy 4016 \(Attachment 5\) Ligature-Suicide Workflows](#)

Patient Identification

(Excerpts from [UC Davis Health Policy 2702](#))

It is the policy of UC Davis Health to ensure that all patients are properly identified prior to any care, treatment or services provided.

In the hospital setting, every patient shall always have a tamper-proof non-transferable ID band applied securely to at least one extremity. Exceptions: Small infants and patients with a disease process, injury,

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or treatment that prevents safe placement of the ID band on any extremity. The band shall include the patient's first and last name, medical record number, date of birth and gender.

Before any procedure is carried out, the identification band shall be on the patient and will be checked for the following two identifiers to ensure that the correct patient is involved:

- Patient name
- Patient medical record number

Staff shall verbally assess the patient to assure proper identification, asking the patient's name and date of birth and matching the verbal confirmation to the written information on the identification band.

Staff will identify the individual patient as the person for whom the service or treatment is intended and match the service or treatment to that individual patient.

No procedure shall be conducted when the patient's identity cannot be verified because the imprinted band is illegible or missing. Patient identification must be confirmed using the two-identifier system prior to conducting any healthcare procedures.

Note: In outpatient settings where the patient is not required to wear an ID band, the two identifiers used to confirm patient identity are the patient's name and date of birth.

Informed Consent

In all non-emergency circumstances, physicians or other authorized healthcare providers must obtain verbal and written permission ("informed consent") of their patients to perform surgical, diagnostic or therapeutic procedures (including blood/ or blood product transfusion) that are considered "complex", where consent is required by law, or if the procedure inherently involves a known risk of serious injury, disability or death.

The patient must be fully informed about the treatment – including the treatment itself, the risks, benefits, and side effects – and the alternatives (and the risks, benefits, and side effects of the alternatives). The patient must know they have the right to accept or refuse the treatment or service, and the foreseeable risk or consequences of such a refusal.

For additional information on Informed Consent, refer to [UC Davis Health Policy 1411](#).

Patient Advance Directives for Healthcare

An Advance Health Care Directive is an instruction stating an individual's preferences regarding medical treatment options and/or designating who should make treatment choices *should the individual lose their decision-making capacity*. In California, these include a Power of Attorney for Health Care, and individual health care instructions (oral or written). All hospital inpatients (adults and emancipated minors) must be asked if they would like to receive written information about Advanced Directives.

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There is now an Advance Care Planning activity in Epic EHR to record and track this type of information. Click on “ACP Documents” or “HCA” in the Storyboard to go there.

For additional information on Patient Advance Directives for Healthcare, refer [to UC Davis Health Policy 1410](#).

Pressure Ulcer Prevention

Pressure Ulcers Present on Admission: Bedside RN must identify, stage, and take a photograph with barcode medication administration device (or Rover) using Haiku app.

For more information on adding clinical images to the patient’s medical record using the Haiku app, review [UC Davis Health Policy 2315 \(Attachment 1\) EMR Clinical Images](#).

See wound website for staging:

http://intranet.ucdmc.ucdavis.edu/woundcare/PDF_Word_Excel/powerpoints%20for%20staging.pdf

No incident report (IR) is needed for pressure ulcers present on admission if the photograph is taken.

Hospital Acquired Pressure Ulcer: fill out an IR and consult with wound care RN for staging

High risk patients:

- Non-ICU: Braden score 18 or below
- ICU Patients: BP < 100/55, HCT < 30, shock, dialysis, spinal cord injury/spinal bifida, projected prolonged or multiple surgeries

HAPU prevention: Think SKIN

S – Surface

Pressure redistribution (Waffle overlay, seat cushion under sacrum or low air loss bed)

Prevent shearing (Silicon Border dressing)

K – Keep turning and repositioning (Q 2 hours)

I – Incontinence (Moisture control: Skin barrier cream, no diaper)

N – Nutrition (Dietitian consult)

***Document all interventions**

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Recognition of Strokes

UCDMC is averaging ~500 strokes per year

Background: UC Davis Health is a Joint Commission designated Stroke Center and everyone needs to know the warning signs of a stroke and what to do in the event of a suspected stroke whether the employee is in the main hospital, parking lot or downtown.

The Stroke Program Mission is to provide the highest quality of stroke treatment through compassionate and innovative health care.

Stroke in the United States

- #1 cause of disability among adults in the US
- 795,000 Americans each year suffer a new or recurrent stroke
- More than 690,000 U.S. stroke are caused when a clot cuts off blood flow to a part of the brain – this is called an ischemic stroke
- KILLS 133,000 people a year. That’s about 1 in every 20 deaths
- Every 40 Seconds someone has a stroke
- #5 cause of death among adults in the US

Warning Signs of a Stroke

- Sudden numbness or weakness of face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden, severe headache with no known cause

A Quick Assessment: BEFAST Examination

- **Balance**: Ask the patient or observe if there is a sudden loss of balance.
- **Eyes**: Ask the patient if there is vision loss in one or both eyes.
- **Facial Droop**: Ask the patient to smile and assess for a facial weakness. Does the patient’s face look uneven?
- **Arm drift**: Ask the patient to raise both arms at a 90-degree angle to the floor and assess for a downward drift.

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- **Speech:** Ask the patient to repeat a simple sentence. Is the patient's speech slurred? Does the patient have trouble speaking or seem confused?
- **Time:** If the symptoms are new, they may be having an acute stroke. Determine onset of symptoms. Call 911.

SPOT A STROKE. SAVE A LIFE: Acting Right Away is Critical

Is a Patient having a Stroke outside of UC Davis Medical Center?

CALL 911

The sooner a stroke victim gets to the hospital, the sooner they'll get lifesaving treatment.

Is a Patient having a Stroke at UC Davis Medical Center?

Follow [UC Davis Health Policy 6006 Responding to Medical Emergency Situations \(Including Code Blue\)](#)

Main Hospital – dial 4-3666 (Code Line); phone number located on back of badge

Other locations on UDCMC property – dial 911

Rapid Response Team (RRT) is available to assess and support the patient

Care of LVAD Patients at UC Davis

UCDMC has an active and growing LVAD program.

VAD patients can be seen throughout the hospital and in clinics.

What is an LVAD?

An LVAD is an implanted continuous-flow heart pump implanted during open heart surgery. The LVAD takes blood from the failing left ventricle and moves it to the aorta to circulate throughout the body. All LVADs contain a Driveline that exits the abdomen and connects to a controller to run the pump and batteries or an AC cable to power it.

Who gets an LVAD?

Patients with advanced heart failure that have failed medical management are considered for advanced therapies. Heart Transplant remains the standard of care for those eligible and able to await transplant. For patients unable to await transplant an LVAD can be placed as a "Bridge to Transplant". For patient's ineligible for transplant an LVAD can be placed as "Destination Therapy". If transplant criteria are later met the patient can be evaluated and changed to a "bridge to transplant" VAD patient.

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VAD equipment the patient will have.

VAD patients' driveline will be attached to a controller and the controller will be attached to 2 power sources, either batteries or wall power. All patients should also have a backup bag containing a backup controller and backup batteries.

Where will VAD patients be admitted in the hospital?

ED, CTICU, MSICU Blue, E6, and E5 PM&R.

Where else will you encounter LVAD patients?

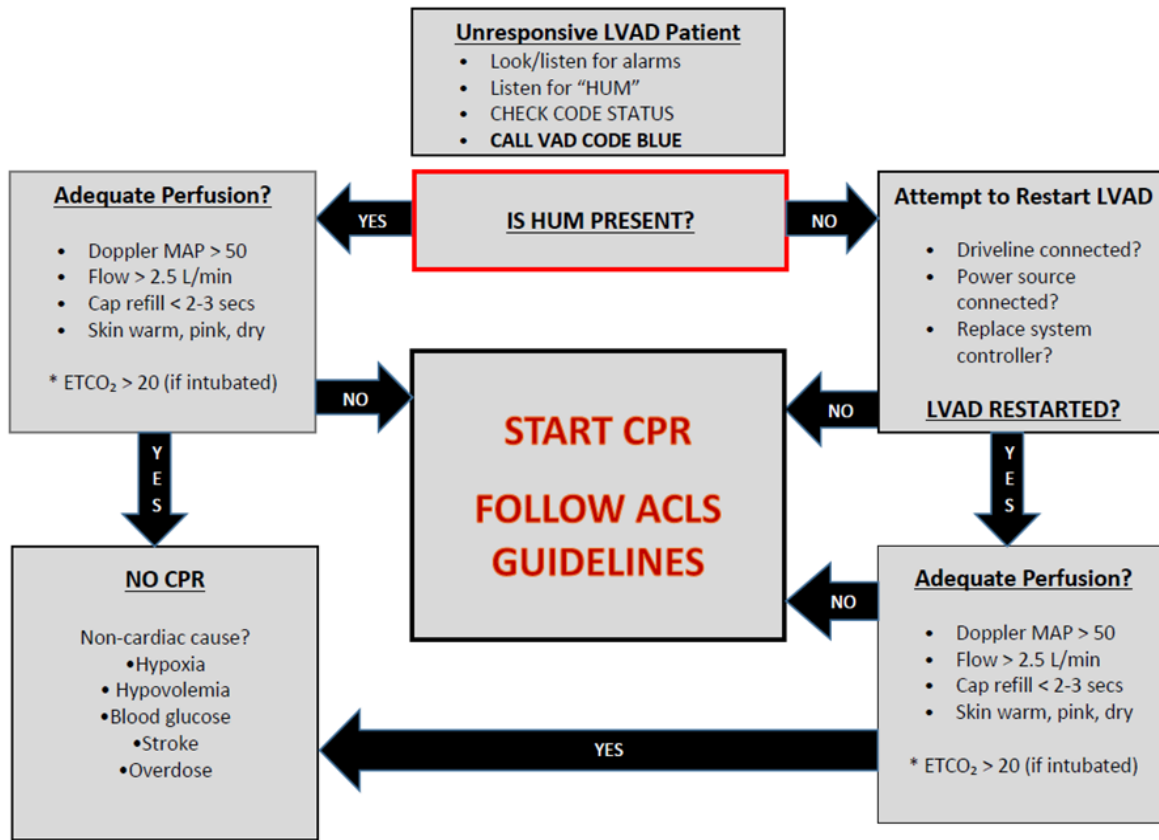
They will be seen in VAD clinic and cardiology clinic. They will also be seen for procedures around the hospital: X-ray, Ultrasound, CT Scan, GI lab, Pre-OP, Post-Op, Cath Lab, EP Lab.

What do you do in case of a VAD patient emergency?

Call the LVAD team. The VAD pager number is (916) 816-7363. The pager is covered 24/7 by a VAD trained nurse or PA/NP.

- Respiratory Arrest
 - In the event of a respiratory arrest, rescue breathing should be initiated using the American Heart Association Guidelines.
 - 10 breaths per minute or one breath every 6 seconds.
- Cardiac Arrest
 - If external defibrillation is necessary, leave the pump running. Do not disconnect the system controller from the percutaneous lead before delivering the shock.
 - VAD patients often do not have a pulse but they should an organized have a heart rhythm.
 - If indicated, CPR can be performed on LVAD patients. See the protocol on treating an unresponsive LVAD patient on the next page.

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- VAD Code Blue
- In the event of a VAD code blue in the hospital, dial 4-3666.
- Inform the operator that it is a “VAD Code Blue”.
- The operator will page the VAD team.
- In the event of a VAD code blue outside the hospital, call 911 and page the VAD team at (916) 816-7363.

Restraints Review

Provide nursing care and documentation for patients requiring restraints according to the restraint policy and procedure. Refer to [UC Davis Health Policies 4069 Restraints](#) and [4070 Use of Restraints Protocol for Specific Patient Conditions](#). Staff is required to be familiar with current policy and to follow policy in providing patient care. Take this time to follow the links provided and read through the current policy related to restraints.

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What is a restraint?

A physical restraint is any manual method or physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely; a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment dosage for the patient's condition.

Four (4) Side Rails is considered a restraint when the intent of use is to restrict patient movement or immobilize or reduce the patient's ability to move freely (e.g. If a patient is physically able to ambulate, even if it has been determined that they cannot safely ambulate and the 4 side rails prevent this, then the 4 side rails must be defined as a restraint). Conversely, if a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four side rails for this patient would not be considered restraint because the side rails have no impact on the patient's freedom of movement. In this example, the use of all four side rails would not be considered restraint. Other examples:

- When a patient is on a bed that constantly moves to improve circulation or prevents skin breakdown, raised side rails are a safety intervention to prevent the patient from falling out of bed and are not viewed as restraint.
- When a patient is placed on seizure precautions and all side rails are raised, the use of side rails would not be considered restraint. The use of padded side rails in this situation should protect the patient from harm; including falling out of bed should the patient have a seizure.

Exclusions:

- Standard practices that include limitation of mobility or temporary immobilization for medical, dental, diagnostic, or surgical procedures, including post-procedure care. For example, the standards do not apply to surgical positioning, intravenous arm boards, radiotherapy procedures, or protection of surgical and treatment sites in pediatric patients.
- Adaptive support used in response to a patient's assessed need. For example, the standards do not apply to postural support, orthopedic appliances, or tabletop chairs.
- Protective equipment, such as helmets.
- Forensic restrictions and restrictions imposed by corrections and law enforcement authorities for security purposes.
- Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers) that a safety-conscious child care provider outside a healthcare setting would utilize to protect an infant, toddler, or preschool-aged child would not be considered restraint or seclusion.

Clinical Justification for the Use of Restraints

- Violent and self-destructive behavior, harmful to self, others, and the environment such as hitting, hair pulling, throwing objects, striking at or biting staff or others, and self-mutilation.

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- Behavior interfering with life-saving and/or necessary medical treatment such as pulling, tugging, grabbing at lines or tubes, picking at open wound, dressings, drains, and traction.
- Behavior indicating patient is unable to follow directions to avoid self-injury, such as sitting at the edge of the bed, transferring in/out of bed, standing or ambulating, without the strength or cognition function of doing so safely.
- The use of restraint is not based on a patient's history of restraint or dangerous behavior.
- A request from a family member for restraint, which they consider as beneficial, is not a sufficient basis for the use of restraints.
- Use of alternative measures has proven ineffective.

The least restrictive method must be considered when using restraints. Refer to [Policy 4069](#), [Attachment 5 Least to Most Restrictive Reference Chart](#) for assistance in selecting the most appropriate and least restrictive method or product to meet the needs of the patients.

Levels of Restraints

Treatment or Non-violent restraint is the use of soft restraints, Posey belts, bed enclosures, and other forms of restraints to protect a child or adult who is confused, disoriented, unable to call for assistance, or unable to follow instruction for their personal safety; or from dislodging a medical device; or from interfering with the integrity of a dressing or wound.

Behavioral or Violent Restraint is the use of a physical or mechanical device to involuntarily restrain the movement of all or a portion of a patient's body as a means of controlling violent or assaultive behavior with the intent to prevent patient from harming self or others.

Restraint Orders/Nursing Care

The healthcare team shall assess the need for use of restraints.

This assessment should include: a physical assessment to identify medical problems that may be causing behavior changes, e.g. hypoxia, hypoglycemia, electrolyte imbalances, etc., and alternative interventions that might prevent the need for restraints.

The RN may initiate the use of restraints upon receipt of a verbal, telephone or electronic restraint order from a provider (MD/DO/NP/PA). If a provider is not available to issue such an order, the RN initiates restraint use based on an appropriate assessment of the patient, notifies the provider within 12 hours of the initiation of restraint and obtains an order.

The provider must be notified immediately upon initiation of restraint for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. PRN (as needed) orders are prohibited. The provider must provide an order for restraint within 12 hours of application of treatment restraints. This must be renewed every 24 hours after a face-to-face

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reassessment of the patient with determination of continued need. An exception to this is patients who meet criteria for protocols for specific conditions or certain specific clinical procedures.

Protocol for Use of Treatment Restraints for Specific Patient Conditions

A provider must issue a patient specific order authorizing the use of restraints. RNs may apply restraints under a protocol with an MD/DO/NP/PA order for specific conditions or certain specific clinical procedures (e.g. post-traumatic brain injury, insertion of intra-aortic balloon pump) to prevent significant harm to the patient (see [UC Davis Health Policy 4070 Protocol for Use of Treatment Restraints for Specific Patient Conditions](#)). In this situation, RNs maintain and terminate restraint in accordance with established criteria defined in the protocol.

Patient Safety in Restraints

The RN is responsible for using appropriate restraints, based on the provider order, and for assessing, monitoring and re-evaluating the patient and restraints.

Monitoring and Assessing Patients in Restraints

The RN and provider can monitor patients in restraint. PT, OT, Speech Therapist, Psycho-Social Vocational Service Provider, Emergency Department Technicians, and Radiology Technologists operate under the direction of the current order and continue to monitor and document when the patient is under their sole supervision.

Assessment will include but is not limited to the following:

- Type of restraint
- Clinical justification
- Restraints appropriately applied, removed, or reapplied
- Whether less restrictive methods are possible
- Vital signs
- Respiratory status
- Circulation, movement, and sensation
- Skin integrity
- Mentation/Behavior/Cognitive Function/Level of distress and agitation
- Bathroom needs
- Fluids/Nourishment needs
- Releasing the restraints to check for injury
- Range of motion performed
- Patient's readiness for release from restraints
- Call light within reach
- Patient dignity and rights maintained

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Discontinuing Restraint Use

The provider and RN have the authority to discontinue the use of restraint.

Restraints will be discontinued as soon as is safely possible even if there is still time left on the order when:

- Improved mental status
- Patient's agreement and compliance with instructions for safety
- Improved ability to sit at edge of bed, transfer or ambulate without risk or injury
- Less restrictive measures are effective
- Patient's lines are discontinued or no longer required for medical treatment
- The need for restraints does not exist, such as discontinuation of medical treatments
- The order has expired

When restraints are terminated early and the patient subsequently exhibits the same behavior that initially required the restraints, a new order is required [CMS 482.13(e) (1) (i) (C) A-0161].

Note: A temporary, directly-supervised release, however, that occurs for the purpose of caring for a patient's need is not considered a discontinuation of the restraint. If the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint.

Risks of Restraint Use

Risks associated with restraint use should be taken into consideration when assessing the need for restraint and determining the monitoring and care needed while restraints are in place. These risks include:

- Patients with cognitive impairment may attempt self-removal, increasing risk of injury.
- Patients may not be able to communicate needs while in restraints.
- Patients in vest/belt restraints may be injured by falling through split side rails.
- Patients in vest/belt restraints may experience respiratory compromise.
- Patients in restraints may exhibit increased agitation.
- Patients may experience psychological distress due to restraints.
- Patients may experience circulatory compromise of restrained extremity.

Elder or Dependent Adult Abuse

Refer to [UC Davis Health Policy 1531 Reporting Suspected Elder or Dependent Adult Abuse or Neglect](#) for complete text of current policy.

How to Detect, How to Intervene

Researchers estimate that nearly two million elderly people are abused each year in the United States. As the population becomes older and sicker, the problem is expected to worsen. To intervene

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effectively, UC Davis Health workforce needs to recognize the symptoms of elder abuse. Additionally, UC Davis Health workforces are legally required to report to the authorities all suspected cases of elder abuse.

Detecting Abuse

Elder abuse is generally categorized under one of four headings: physical, psychological, financial, or neglect. It is not unusual for several types of abuse to occur simultaneously.

Physical Abuse is defined as the infliction of physical harm or injuries, including sexual abuse or misconduct. Physical abuse commonly takes the form of hitting, slapping, pushing, punching, pinching, burning, or striking with objects. An abused older adult may be loyal or fearful of the abuser or ashamed to acknowledge dependency on the abuser, thus they are not willing to report physical abuse. Classic signs include:

- Wounds inconsistent with explanation of how the injury occurred
- Bruises at several stages of healing
- Delay in seeking treatment
- Suspicious behavior by family member or caregiver

Psychological Abuse is defined as inflicting emotional pain or distress on the victim. It usually occurs with physical abuse, but it can also occur alone. It may be difficult to detect psychological abuse unless physically present to witness such overt examples as threats, insults or humiliation. A red flag should be raised when:

- The elderly patient's caregiver seems indifferent or angry toward them.
- The patient is withdrawn, isolated, depressed, demoralized or fearful toward their caregiver.

Financial Abuse is defined as when a family member, caregiver or friend takes control of the elder's resources either through misrepresentation, coercion, or theft. The victim of this type of abuse may or may not realize what is happening. A red flag should be raised when:

- The patient mentions they lack money for food, household supplies, and/or prescription drugs.
- The patient's nutritional status is poor.
- The patient mentions they are no longer allowed by their caregiver to live in their home.

Elder Neglect is a blanket term used to describe situations in which the well-being of the older adult is judged to be at risk due to lack of attention to him/herself or their living environment. Neglectful behaviors range from failure to meet nutritional and hygienic needs to suicide or manslaughter. Elder neglect may occur when:

- The care needed exceeds the caregiver's ability to deliver.

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- The caregiver is ignorant.
- The patient no longer can care for him/herself due to declining capacity.

<i>Risk Factors for Elder or Dependent Adult Abuse</i>		
Condition	Victim	Abuser
History of mental illness	X	X
Shared living arrangements	X	X
Family history of violence	X	X
Isolation	X	
Stressful events		X
Poor health	X	
Cognitive impairment	X	
Substance abuse		X
Dependency	X	X
Lack of financial resources	X	X

How to Report Elder or Dependent Adult Abuse

Telephone the Department of Clinical Social Services immediately (916-734-2583) or after hours page the Crisis Services social worker (916-816-5585) to notify them of the patient’s name and location.

Telephone appropriate agency as soon as possible to notify them of the suspected abuse and that the report form will follow.

If the elder or dependent adult lives in the community and outside a long-term care facility, contact Adult Protective Services (in Sacramento County 916-874-9377) or local law enforcement agencies.

If the elder or dependent adult lives in a long-term care facility, contact the Ombudsman Program (in Sacramento County 916-448-3494) or local enforcement agencies.

Complete the Elder and Dependent Adult Abuse Reporting Form (SOC 341) promptly. Place a copy in the medical record and hand deliver the original and remaining copy to the Department of Clinical Social Services, Suite 1300, Professional Support Services Building.

If you are concerned that the patient’s proxy has, or might get, access to the patient’s notes via MyChart, you may block release of these notes IF, in your professional judgment sharing these notes might lead to physical harm to the patient. Document this reason for note blocking with the SmartPhrase .NOTSHARINGNOTE.

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Child Abuse

Refer to [UC Davis Health Policy 1528 Reporting and Management of Suspected Child Abuse, Neglect and Sexual Abuse](#) for complete text of current policy.

Mandated reporters must immediately, or as soon as practically possible, report by telephone to a child protective agency all cases of suspected child abuse and neglect discovered when acting in their professional capacity or within the scope of their employment when the suspected child abuse victim is under 18 years of age. A written report shall be submitted to the same agency within 36 hours of receiving information concerning the incident. The mandated reporter may also include with the report any non-privileged documentary evidence relating to the incident. The same person should make both the telephone and the written report.

Questions regarding reporting procedures and psychosocial issues should be addressed to the Department of Clinical Social Services at 916-734-2583 or Dr. Kevin Coulter can be consulted at 916-816-7134.

Weekdays (8:00 a.m. to 5:00 p.m.): Contact the office at 916-734-2583.

Weekends/Holidays (8:00 a.m. to 5:00 p.m.): Contact a Pediatric Social Worker on pager 916-816-5283.

All other hours: Contact a Crisis Social Worker on pager 916-816-5585.

For infants and children evaluated in the Emergency Department or Pediatric Inpatient Units who have injuries concerning for child abuse, a formal child abuse consultation can be obtained by paging the Child Protection Team at 916-451-5011.

If you are concerned that the patient's proxy has, or might get, access to the patient's notes via MyChart, you may block release of these notes IF, in your professional judgment sharing these notes might lead to physical harm to the patient. Document this reason for note blocking with the SmartPhrase .NOTSHARINGNOTE. You could include this in a secondary non-shared note, while leaving less sensitive information in the main, shared note.

Blood Product Administration and Transfusion Reaction

Refer to [UC Davis Health Policy 13012 Administration of Blood and Blood Components](#) for complete text of current policy.

Licensed Personnel Responsibilities

Preparing for Blood Product Transfusion

Verify MD transfusion order and identify availability of blood products.

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Verify a current, signed consent for blood. At minimum, the elements of consent shall include a description of the risks, benefits, and treatment alternatives (including non-treatment); the opportunity to ask questions; the right to accept or refuse transfusion.

Informed consent for blood administration covers all blood administration for a hospital admission.

Outpatient infusion areas for adults and children, informed consent for blood administration is valid for one year with chronic conditions, and throughout the patient's course of treatment for transient conditions lasting less than one year.

Patient Education

Provide patient/family education related to transfusion of blood products. For outpatient, elective transfusions the current version of the California Department of Public Health brochure A Patient's Guide to Blood Transfusion must be provided.

A physician, RN, CRNA or perfusionist must explain the procedure to the patient, patient's family, or to the patient's lawfully authorized representative.

Obtaining Specimen for Type & Cross/Type & Screen

Two patient identifiers must be used to confirm identity prior to any specimen collection or transfusion. Appropriate identifiers are: name, MRN, date of birth and/or SSN.

EMR Lab label must have date, time, and first and last name of person drawing the blood. If any corrections need to be made to the automatic, computer generated label that is printed, a single line should be made through the printed information and any corrections can be made by handwriting the correct information. Any hand-written information should be made in block letters. For the specimen collector, a minimum of first initial and full last name should be provided.

All specimens must be labeled at the bedside in the presence of the patient for Blood Bank testing.

If requested by the lab, draw a specimen for ABO verification. This specimen must be collected by someone other than the person who drew the original blood specimen and must be collected at least five minutes before or after the Type and Screen specimen.

Transporting Blood Outside the Lab

- Maintain the blood at an even temperature.
- DO NOT set blood on a tray with or carry blood close to hot or cold packs, drinks, or other materials.
- Protect blood from sharp objects.

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Administering Blood Products

When blood product is available for issue (“Crossmatch” or “XM” status in EMR), the RN or designee will bring a demographic label to pick up blood product for the patient. The demographic label must contain two patient identifiers. Appropriate identifiers are: name, medical record number (MRN), date of birth, and/or social security number (SSN).

At blood issue, the following information shall be verified:

- Intended recipient’s two independent identifiers, ABO group, and Rh type
- Donation identification number, the donor ABO group, and the donor Rh type if required
- Interpretation of the crossmatch tests, if performed
- Special transfusion requirements, if applicable
- Unit has not expired

After issue and immediately before transfusion, the following information shall be verified by a two person check in the presence of the patient. One person shall be the licensed transfusionist (person who will be administering the blood product).

- The intended recipient’s two independent identifiers, ABO group, and Rh type
- The donation identification number, the donor ABO group, and if required the Rh type
- The interpretation of crossmatch tests, if performed
- Special transfusion requirements, if applicable
- The unit has not expired.

Initiation of Transfusion and Monitoring of Patient

Obtain baseline vital signs (temperature, pulse, blood pressure, respiratory rate, and SpO₂) immediately prior to the transfusion.

Initiate the transfusion slowly (< 30 ml in the first 15 minutes).

Remain with the patient for the first 15 minutes after blood enters the vein, observing for adverse event.

Observe the patient at least every 30 minutes during the transfusion and at least 30 minutes after the transfusion. Repeat vital sign measurement at 15 min, 30 min, and at the end of the transfusion.

Document the transfusion in the transfusion record per patient care area. By state and federal laws, the record must contain:

- The transfusion order
- Documentation of patient consent
- The name of the component (i.e. red blood cells, platelets, etc.)

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- The donation identification number
- The date/time of transfusion start/stop
- Pre- and post-transfusion vital signs
- The amount transfused
- The identification of the licensed transfusionist
- If applicable, transfusion-related adverse events

Used blood bags must be kept *for at least 6 hours post transfusion* in the event of a subacute transfusion reaction and need for further testing/evaluation of the product.

Recognizing Transfusion Reactions

Any change in a patient's condition while blood is being administered should be considered a possible reaction to the transfusion.

Acute reactions occur immediately, subacute reactions occur within 6 hours and delayed reactions occur up to several months after the completion of the transfusion.

Signs and symptoms of ACUTE reactions include:

- Fevers (increased temperature of >1-degree C during or immediately following transfusion)
- Chills
- Itching or urticaria (hives)
- Pain (flank pain, IV site pain, chest pain, or other sites)
- Sudden onset of dyspnea, drop in SpO₂, or sensation /complaint of difficulty breathing
- Hypotension (sudden drop of blood pressure > 40 mm Hg)
- Hypertension (sudden increase in blood pressure >40 mm Hg)
- Hemoglobinuria
- Complaint of a sense of impending doom
- Sudden decrease in urine output
- Unexplained bleeding or oozing from puncture or incision sites
- Chest pain
- Pulmonary edema
- Shock
- Altered mental status

Signs and symptoms of DELAYED reactions include:

- Unexplained onset of jaundice
- Unexpected decrease or failed increase in hemoglobin occurring 5-13 days after transfusion
- Unexpected elevation in liver function tests
- Sudden and unexplained rash or diarrhea 6-10 days after transfusion

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- Sudden drop in platelet count 5-10 days after transfusion

At First Sign of an Adverse Reaction:

- Stop the transfusion immediately.
- Keep IV open with normal saline infusion, use a new administration set
- Check patient identification and donor unit match to confirm patient is receiving correct unit.
- Notify physician immediately.
- Notify Transfusion Service STAT and describe symptoms.

At Transfusion Service's request, send properly labeled samples ASAP.

Send the remaining unit or empty blood bags, the Y-filter administration set and clamped IV fluids to Transfusion Service for follow-up as described [UC Davis Health Policy 13012 Administration of Blood and Blood Components](#).

Physician or nurse to complete the Transfusion Reaction Investigation form and return to Transfusion Service ASAP. Do this STAT if patient requires additional transfusions.

See policy for specific pediatric and neonatal requirements

Baby Friendly Hospital Initiative

The Baby Friendly Hospital Initiative (BFHI) focuses on protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services. It is critical that the BFHI program is integrated with all other aspects of breastfeeding protection, promotion and support. The core purpose of the BFHI is to ensure that mothers and newborns receive timely and appropriate care before and during their stay in a facility providing maternity and newborn services, to enable the establishment of optimal feeding of newborns, which promotes their health and development.

UC Davis Health staff will actively support breastfeeding as the preferred method of providing nutrition to infants. A multidisciplinary, culturally appropriate team comprising physicians, nursing staff, lactation consultants, nutrition staff, and other appropriate staff shall be established and maintained to identify and eliminate institutional barriers to breastfeeding. On a yearly basis, this group will evaluate data relevant to breastfeeding support services and formulate, along with administrators, a plan of action to implement needed changes.

Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.

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4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if separated from their infants.
6. Give infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming in – all mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mother to them on discharge from the hospital or birth center.

Refer to [UC Davis Health Policy 16025 Breastfeeding Guidelines](#).

Cyber-Security Threats

Account/Password Protection

- Keep university and personal accounts separate and use different credentials for each
- Use a passphrase (UPPERCASE letters, numbers, and special characters) that you can remember; the longer the better and never share it.
- Use a unique passphrase for each site. If one passphrase gets compromised, the others will still be safe.
- Use complex passwords (Uppercase letters, numbers, special characters), and never share passwords.
- Using multi-factor authentication (MFA) wherever possible to maximize protection.

Please contact the UCD Health IT Helpdesk (916) 734-4357 (4-HELP) for assistance if you have any questions or concerns.

Malware/Virus

- Just one malware/virus infection can have a severe impact to UC Davis Health operations. If you encounter any unusual behavior or messages on any computer you access or have questions, please contact the UCD Health IT Helpdesk (916) 734-4357 (4-HELP) for assistance.

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Phishing

Phishing is a deceptive practice by attackers that uses emails, texts, social media posts, pop-ups, or phone calls to infect computers and steal PHI or other sensitive/personal information such as: names, passwords, SSNs, addresses, etc.

Ransomware

Email is how most ransomware infections get into a network. The attacker wants to infect computers with malicious software designed to block access to a computer system until a sum of money is paid.

What are attackers after?

- Money – They will try to steal money or influence user’s contacts (coworkers, family, and friends) to wire money.
- Access – Compromise user accounts to gain access to sensitive data and systems.
- Identity – Impersonate a user to continue email attacks to others by sending more phishing emails.
- Information Gathering – About family, friends, coworkers, and patients for malicious use

If you receive suspicious emails or other types of messages, **DO NOT OPEN, CLICK, OR REPLY TO THEM.** Do not open any attachments or click on any links either. Forward the original email as an attachment to abuse@ucdavis.edu for review by IT Security and follow their instructions. Contact the UCD Health IT Helpdesk (916) 734-4357 (4-HELP) for assistance.

Securing and Encrypting Portable Electronic Devices

Portable electronic devices such as laptops and USB keys can be a convenient way to transport and store Information. These devices, however, pose a high-risk of compromising data, privacy and security when misplaced or stolen.

UC Davis Health data should be stored on a secured UC Davis Health IT network location or UC Davis Health Office 365 OneDrive. Laptops used for UC Davis Health business should always be issued by the University and must be encrypted. If you need to use a USB drive to carry data, the drive should be encrypted, password protected, and issued by UC Davis Health IT. To obtain an IT-issued USB drive, submit a request online through the Employee Self-Service portal or by calling the IT Help Desk at 916-734-HELP (4357).

Photography and Video Recording

- Photographs and videos documenting patient care are a valuable means for advancing clinical, educational, and research objectives. This activity, however, presents an inherent risk to patient privacy because it typically includes identifiable information (e.g. patient arm with unique injury/skin condition and identifiable tattoo or enough of a patient’s face). Therefore, the utmost care should be taken with how photographs and/or videos are taken, stored, and used at UC Davis Health.

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- Written patient consent is required in advance of any photography or video recording UNLESS the photography is solely for clinical purposes or internal educational purposes.
- All clinical photography should be obtained and retained via a secure means. When being used for medical treatment, the images should be uploaded in the patient’s electronic medical record. Images not used for medical treatment should be uploaded on a UC Davis Health secure server, such as the Shared or “S” drive.
- Haiku (a mobile app available for iOS and Android devices) and Canto (an iPad app) can be utilized to retain and upload patient photos and must be used for patient photos for clinical use. Use of native smartphone camera apps by workforce members as a means to capture or store photographs or video recordings is strongly discouraged. When native smartphone camera apps must be used, the device must not automatically backup or upload to a non-HIPAA compliance storage location (e.g., cloud storage).
- To minimize risk to patient privacy, photographs and videos containing patient information should be promptly deleted from the recording device once incorporated into the patient’s record.
- Please review the following policies for additional information about protecting PHI on mobile or hand-held devices, photography expectations, and medical documentation requirements:
 - [UC Davis Health Policy 1313 Protected Health Information \(PHI\) or Personal Information \(PI\) on Mobile Devices and Personal Computers;](#)
 - [UC Davis Health Policy 1426 Authorization and Consent to Photograph or Interview;](#)
 - [UC Davis Health Policy 2315 Incorporating Paper Records/Media into the EMR](#)

Social Media

Social media is a valuable way of interacting and communicating ideas. However, social media in a healthcare setting can presents high risks to the organization’s commitment to confidentiality and patient privacy.

[UC Davis Health Policy 1307 Social Media Policy](#) establishes the social media usage rules for UC Davis Health workforce members and these rules apply whether students or employees are posting to their own sites, managing an official UC Davis Health site or simply commenting or posting on other sites. For example, the policy expressly prohibits workforce members from using or disclosing patient information on any social media platform **unless** they have obtained written authorization from the patient.

Examples of risky posts include:

A photograph taken in a work area where a patient or computer screen is visible in the background,
or

Commenting about a specific patient case (e.g. “I saw a patient with a snake bite in the ED today”) which is seen by and “identifiable” to the patient’s family

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It is important to be extremely conscientious when posting about the workplace on social media and staff should be mindful of any content they post online to ensure patient confidentiality. Below are more detailed rules for appropriately using social media accounts.

- **Do not share confidential or proprietary information about the University on social media sites.** This includes company competitive information, financial information, intellectual property and business e-mail messages.
- **Do not use the University name to imply or create the impression that your opinions represent those of the University.** If you identify your affiliation to UC Davis Health or your connection to the University is apparent, make it clear that you are speaking for yourself and not on behalf of UC Davis Health. For example, you can make a disclaimer saying, “The views expressed on this site are my own and do not reflect the views of my employer.”
- Before creating an official University social media account, email Public Affairs at hs-socialmedia@ucdavis.edu. You must receive approval from the Public Affairs & Marketing team and follow all established policies and guidelines.
- **Employee personal social media accounts should not reference the UC Davis Health name or trademarks.** While this includes the title of the site, the social media name and even the web address, employees can, however, accurately describe their relationship to the University. For example, stating that you work at UC Davis Health on your LinkedIn page is appropriate, but a blog titled “UC Davis Health Physicians Give Advice” would be inappropriate.
- **Do not use or disclose ANY patient information on any social media site without the patient’s written permission.** This includes personal and University-hosted accounts. Even if the individual is not directly identified, if it is possible for that person to be identified by the information posted, then it could be a HIPAA violation and carry heavy personal and organizational penalties. All patients referenced, quoted, described or otherwise identified on any social media site, must complete a UC Davis Health Patient Authorization form as outlined in [UC Davis Health Policy 1426](#).
- **UC Davis Health discourages “friending” or following patients and staff should not initiate or accept such requests** except under special circumstances. For example, accepting a request when the friendship pre-dates the treatment relationship. Managers are also discouraged from initiating “friend” requests with employees they manage. However, managers can accept requests if they believe it will not negatively impact the work relationship.

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Additional social resources are available in the [UC Davis Health Social Media Toolkit](#) and the following UC Davis Health Policies:

- [UC Davis Health Policy 1307 Social Media Policy](#)
- [UC Davis Health Policy 1426 Authorization and Consent to Photograph or Interview](#)
- [UC Davis Health Policy 1302 Protected Health Information/Personal Information Breach Notification](#)

Compliance and Privacy Services

UC Davis Health Compliance Program

UC Davis Health's Compliance Program is a comprehensive effort to promote compliance with existing healthcare rules and regulations. Globally, the Compliance and Privacy Services Department (Compliance Department) is responsible for:

- Understanding the rules and regulations;
- Promoting a culture of compliance and ethical behavior;
- Implementing controls to identify risks;
- Monitoring and auditing risks;
- Investigating possible non-compliance matters; and
- Working collaboratively with operations to resolve issues when they occur.

The primary areas of focus for the Compliance Program include Privacy and Patient Confidentiality, Research Compliance, Billing and Coding, Investigations, and Vendor Relations/Conflicts of Interest and other General Compliance areas.

The Chief Compliance Officer (CCO) is the individual employed at UC Davis Health who is charged with overseeing the UC Davis Health Compliance Program. The current Chief Compliance Officer is Shara Rasmussen, JD, MPH, CHC, CHPC.

The rules governing the healthcare industry can be complicated. For this reason, it may be challenging to make the right choices when it comes to healthcare compliance. If you have any compliance questions or concerns, please ask for help. It is always better to ask before taking an action that might not adhere to regulation or institutional policy. Staff may contact the Compliance Department in the following ways:

Phone: (916) 734-8808

Fax: (916) 734-0222

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Online Inquiry Form: <https://health.ucdavis.edu/compliance/contact/>

General Email: hs-compliancehelp@ou.ad3.ucdavis.edu

Privacy & Security: hs-privacyprogram@ucdavis.edu

Research Compliance: hs-researchcompliance@ou.ad3.ucdavis.edu

Compliance Training: HS-ComplianceTrain@ou.ad3.ucdavis.edu

General Compliance Training

What is Health Care Compliance and Why is it So Important?

In short, health care compliance is the ability to act in accordance with a set of rules that relate to health care practices. In health care, compliance programs are developed according to the Federal Sentencing Guidelines which establishes the government's expectation of how a compliance program should operate. According to these federal standards, a complete health care compliance program includes:

- A Chief Compliance Officer and a Compliance Executive Committee;
- Compliant and Ethical policies and procedures;
- Compliance training/education for workforce members;
- Methods for reporting non-compliance and wrongdoing;
- Auditing/Monitoring of organizational activities;
- Fair and consistent enforcement of the rules; and
- Investigations of potential instances of non-compliance and wrongdoing.

Ensuring compliance with health care rules is an important part of patient care. Additionally, it is required in order to participate in federal health care programs. Accepting government funding requires that we follow all relevant federal, state and other rules for how we care for our patients, how their services are billed and how we keep their records. Specifically, the government expects us to provide medically necessary services and to bill them appropriately for that care. Failure to do so could lead to harsh penalties can include, but are not limited to:

- Contract termination,
- Mandatory training or re-training,
- Employment termination,
- Loss of license,
- Criminal penalties & imprisonment,
- Large financial penalties/fines, or
- Exclusion from participation in all federal health care programs.

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UC Davis Health Code of Conduct

The UC Davis Health Code of Conduct is a tool to guide staff in understanding the organization's expectations for acting with integrity. The Code of Conduct consists of various standards, which address known areas of compliance risk. Each standard provides information on the appropriate conduct to follow and suggestions for handling problems that may arise.

All individuals at UC Davis Health are expected to read and fully understand the Code of Conduct. The UC Davis Health Code of Conduct is in Appendix B of this document. An online version can be found at http://www.ucdmc.ucdavis.edu/compliance/general/code_of_conduct/.

After reading the Code of Conduct:

- Staff are expected to avoid involvement in illegal, unethical or otherwise improper acts;
- Staff should seek guidance from the Compliance Department if they are unsure about the permissibility or appropriateness of an activity;
- Staff must promptly report any perceived violations of the Code of Conduct, rules and regulations, policies, or the Compliance Program to the Compliance Department;
- Staff must cooperate during the investigation of any alleged violations; and
- Staff should immediately notify the Compliance Office if the government excludes staff from participation in any federally-funded or state-funded programs.

University of California Statement of Ethical Values and Standards of Ethical Conduct

In addition to UC Davis Health's Code of Conduct, the University of California (UC) has also adopted a Statement of Ethical Values which contains 12 standards that apply to all members of the UC community. Staff are also expected to read, understand and abide by these ethical standards. The Standards can be found online at: <http://www.ucop.edu/ethics-compliance-audit-services/files/stmt-stds-ethics.pdf>.

Reporting Compliance Concerns

To remain a compliant organization, it is necessary for staff to report incidents of non-compliance or concerns to the Compliance Department immediately even if they are not sure if there is a violation. You will not be penalized for making a good faith report even if the report cannot be verified.

All members of the UC Davis Health workforce have an obligation to report activities they suspect:

- Are harmful to a patient, resident, family member, or staff member;
- Are illegal or unethical;
- May have compromised patient privacy or confidentiality;

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- Violate any state or federal healthcare program requirements; and/or;
- Violate the Code of Conduct or a UC Davis Health policy or procedure.

All reported concerns are investigated or reviewed, and appropriate follow-up action is taken. It is never acceptable to overlook actual or potential wrongdoing.

In addition to contacting the Compliance Department directly (using the contact information listed above), staff may also report concerns to the UC Compliance Hotline. The hotline is available 24 hours a day, 365 days a year, and hotline reports can be handled anonymously. The Compliance Hotline can be reached at (800) 403-4744 or online at www.universityofcalifornia.edu/hotline.

Please note that all observations or reports regarding sexual misconduct experienced by patients must be reported to the Harassment & Discrimination Assistance and Prevention Program (HDAPP) at (916) 734-3417 or hdapp@ucdavis.edu, or the UC Davis Title IX Officer at (530) 752-9466 or wjdelmendo@ucdavis.edu.

Protection from Retaliation

Open communication and the freedom to report concerns regarding the operations or ethics of the organization are essential to the Compliance Program's success. Retaliation, retribution, or harassment of anyone who makes a good faith report regarding a violation will not be tolerated. In addition, UC policy, federal law and state law protect any whistleblower employee or applicant for employment from retaliation for having reported an issue or whistleblower report. The UC Whistleblower Protection policy can be found online at <https://www.ucop.edu/uc-whistleblower/>.

Important Compliance Standards

False Claims Recovery Act

After patient care is provided and documented, caregivers and coders translate documentation into a bill for payment. When a bill is submitted to the government for payment from the Medicare or Medicaid programs, a "claim" has been created. Clear and complete documentation is always part of good care, but, without it, the UC Davis Health cannot bill for the services provided.

UC Davis Health must seek to ensure that bills for services are medically necessary and provided in the manner stated on a claim. A claim for payment of services that does not meet these requirements could be a "False Claim."

What are Examples of a False Claim?

Under the Federal False Claims Act (FCA), the federal government may prosecute, criminally or civilly, individuals or entities, who submit or cause to be submitted, claims for payment, when the claims are false. In the healthcare industry this includes Medicare, Medicaid, and other federal healthcare programs. Some examples of a false claim include, but are not limited to:

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- Billing twice for the same service;
- Billing for services not rendered;
- Billing for medically unnecessary services or falsifying certificates of medical necessity;
- Unbundling or billing separately for services that should be billed as one;
- Creating false medical records or treatment plans to increase payments;
- Failing to report and refund overpayments or credit balances;
- Physician billing without personal involvement for services rendered by medical students, interns, residents or fellows in teaching hospitals; and
- Giving and/or receiving unlawful inducements to healthcare providers for referrals for services.

Preventing Fraud, Waste and Abuse

Fraud, waste and abuse (FWA) typically occurs when someone is trying to get payment or benefits from the government that they are not entitled to. Even when FWA laws are violated unintentionally, penalties can still be imposed on the organization or an individual. It is important that all UC Davis Health personnel become familiar with the FWA rules, and refrain from any of the following activities:

- Fraud: Knowingly billing for services/supplies not provided, or knowingly altering claim forms, medical records, or receipts to receive a higher payment.
- Waste: Conducting excessive office visits or writing unneeded prescriptions, ordering unnecessary laboratory tests.
- Abuse: Billing for brand name drugs when generics are dispensed.

[UC Davis Health Policy 1936 Deficit Reduction Act Compliance](#) provides detailed information about the False Claims Act and the University's administrative remedies for false claims and statements. Additionally, departmental policies and workflows often incorporate regulatory rules and requirements. Adhering to these standards is the first step in complying with the FCA rules and preventing FWA. Other things UC Davis Health employees can do to prevent FWA are to:

- Look for suspicious activity
- Perform job duties and other work-related responsibilities in an ethical manner
- Ensure accurate and timely processing or documentation of data/billing
- Follow all applicable laws, regulations, policies and standards of conduct
- Report FWA or any instances of non-compliance to the Compliance Department immediately

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Anti-Kickback Statute

A kickback is when providers accept payment from a third party in return for prescribing or using their products or services. The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying any type of compensation in exchange for referrals for services that are paid, in whole or in part, under a federal health care program like Medicare or Medi-Cal. This means that federal law prohibits you from accepting anything of value from third parties in exchange for referring patients or for ordering items or services.

Violations of these rules are punishable by a fine up to \$25,000 and/or imprisonment up to 5 years.

Conflicts of Interest

A conflict of interest (COI) occurs when an employee influences a decision for individual financial gain. In health care, this results in a conflict between the primary goal of providing safe and efficient patient care and the personal or financial goals of the individual or the entity. These conflicts can be actual or perceived. For example, if a provider is accepting funds from a drug or device company, it could be *perceived* that the company's payments to the provider are influencing their clinical or prescribing decisions even if the provider is doing what is best for the patient. Even perceived conflicts can negatively affect our ability to provide quality patient care, so they should be avoided as well. Whether the conflict is actual or perceived, it is important that you are aware when a conflict may exist and that you avoid or remove the conflict as soon as possible.

Gifts

A gift is any payment or thing of value for which the recipient does not provide a service of similar or greater value in return. Below are some of the basic rules regarding gifts:

- UC Davis Health workforce members are prohibited from accepting gifts from vendors and their representatives.
- Gifts can include free or discounted items, samples, food or other travel reimbursement.
- Honoraria provided for a legitimate service rendered (e.g., delivering a speech) is not considered a gift so long as payment is equivalent to the service rendered.

Additional information about the University's gift rules can be found at:

- UCOP Acceptance of Gifts Policy:
<https://policy.ucop.edu/doc/1200366/AcceptanceofGifts>
- UCOP Health Care Vendor Relations Policy:
<https://policy.ucop.edu/doc/5000433/HealthVendorRelations>
- [UC Davis Health Policy 2204 Gifts and Interactions with Vendors](#)

Vendor Access Program

The UC Health Care Vendor Relations policy provides system-wide standards aimed at reducing the potential for industry influence on our providers' University and patient care decisions.

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Proper vendor credentialing helps UC Davis Health ensure a safe patient and work environment, but also the necessary controls to uphold our values of integrity in every situation. As such, the University has implemented the Reprax tool to monitor vendors who visit our campus and has developed policies to govern employee interactions with vendors. While it is important for vendors to understand and uphold University policies and standards, it is equally important for the UC Davis Health workforce to understand these rules and hold visiting representatives accountable. Vendors who do not follow federal, state, and University rules should be asked to leave and/or reported to the Purchasing Department by calling (916) 734-2475.

Representatives entering any of the UC Davis Health facilities must:

- Register with SEC³URE (also known as Reprax);
- Complete all credentialing requirements;
- Comply with the Vendor Access Program rules;
- Maintain up-to-date credentials in Reprax;
- Wear the Reprax issued badge so that is clearly visible to all staff and other visitors; and
- Follow all federal, state and University rules.

If you have any questions related to vendor compliance or need to report vendor non-compliance, please contact the UC Davis Health Compliance Department directly at <https://health.ucdavis.edu/compliance/contact/>.

Additional information about the Vendor Access Program can be found in the following resources:

- **Frequently Asked Questions:**

https://health.ucdavis.edu/compliance/general/Vendor_Compliance/VendorCompliancePage.html

- **Summary of Vendor Access Rules for Workforce Members:**

<https://health.ucdavis.edu/compliance/pdf/Reprax/1%20Pager%20Workforce%20FINAL.pdf>

- **Summary of Vendor Access Rules for Vendors:**

<https://health.ucdavis.edu/compliance/pdf/Reprax/1%20Pager%20Vendor%20FINAL.pdf>

Open Payments/Sunshine Act

The Sunshine Act requires public reporting of payments to physicians and teaching hospitals from pharmaceutical and medical device companies through the CMS Open Payments program in order to

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increase transparency in payments made to physicians by these manufacturers. Payments and other ‘value transfers’ are published on a yearly basis on the [CMS Open Payments program website](#). Each year, the Compliance Department reviews the Open Payments data to ensure compliance with relevant conflict of interest and conflict of commitment guidelines and regulations.

UC Davis Health Privacy Program

UC Davis Health’s Privacy Program focuses on maintaining the confidentiality and privacy of patient information. In addition to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), its implementing regulations, and the Health Information Technology for Economic and Clinical Health of 2009 (HITECH), California has several state laws governing health information privacy, including the Confidentiality of Medical Information Act (CMIA) and the Information Practices Act.

As a workforce member, you are always required to protect patient information. While this obligation may be challenging given the dynamic nature of your operations, UC Davis Health has many resources available to assist you with this duty. If there are questions about privacy, please call the UC Davis Health Compliance and Privacy Services Department main line at (916) 734-8808 or email the Privacy Program at hs-privacyprogram@ucdavis.edu.

Important Privacy Topics

Access to Patient Information

UC Davis Health is committed to ensure the confidentiality of our patients’ information. To ensure patient information is kept secure and confidential information should only be accessed *for a work purpose*. The public health climate of 2020 can lead to anxiety and curiosity about the health status of others around us and so it is important—now more than ever—to be diligent in protecting and limiting access to our patient’s information. Some important privacy reminders related to accessing patient information:

- Patient information must only be accessed when performing a job function. It is never permissible to use or access patient information for a non-work purpose. For example, it is not permissible to access a patient’s electronic medical record (EMR) out of curiosity.
- **Do not use EMR credentials to access your own record or the record of family members.** Health information should be accessed via a MyChart account or by requesting the medical record from Health Information Management.
- Do not access the patient information of your co-workers, friends, or family members *UNLESS* they are your current patient and/or you are performing assigned employment duties and responsibilities for them.
- As part of the Privacy Program, user access to the EMR is monitored on a regular basis. Any access that appears to be without a work purpose will be immediately investigated. Intentional

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access to EMRs without a work purpose can result in disciplinary action up to and including termination.

Disclosure of Patient Information

Disclosure of patient information should only occur to facilitate a work function. Some important privacy reminders related to disclosing patient information:

Physical Disclosure – Many reportable privacy incidents involve the mishandling of paper documents. These incidents are unintentional and may be avoided by taking some simple steps:

- Promptly pick up printed information from a printer and/or fax machine.
- Have a process for doubling checking documents prior to delivery or sending.
- Implementing processes.
- Highlight or otherwise check identifiers on printed documents before disclosing them.

Electronic Disclosure - Transmitting patient information through email, fax, or any other electronic means to the correct recipient ensures confidentiality and protects against threats to the security or integrity of the information. Some recommendations to minimize this risk include:

- Verify you have the correct email address or fax number for the intended recipient.
- Only use MyChart to communicate with patients.
- When transmitting patient information via email to any non-UC Davis Health recipient, the email should also be encrypted in accordance with [UC Davis Health Policy 2442 E-mail Communication that Contains Protected Health Information or Personal Information](#).
- Forwarding work emails to a non-UC Davis Health email account (e.g. Gmail, Yahoo, or any other email account) is not allowed. For additional information, please review [UC Davis Health Policy 1314 E-Mail Use for UCDCM Personnel \(Employees, Faculty, Staff, Volunteers and Students\)](#).

Verbal Disclosure – When discussing patient information for treatment and/or other work-related purposes in an unsecure location (e.g., in a hallway, waiting room, cafeteria), it is important to maintain patient confidentiality to prevent improper disclosure. Some recommendations to minimize this risk include:

- Discussions about patients should occur in a confidential space and not in a hallway, waiting room, or other public space.

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- Be mindful of your speaking volume when talking with patients or anyone involved in a patient's care.
- Obtain the patient's authorization, to allow them to agree or object, prior to disclosing PHI to a family member or close personal friend.

Reporting Privacy Incidents

UC Davis Health is required to investigate any potential breach or misuse of patient information. This includes both intentional and inadvertent privacy events. As an organization, all these events must be promptly reported to Compliance and Privacy Services. The failure to report such events can result in significant fines and penalties against the organization and the individuals involved.

Promptly report a known or suspected breach of patient information to the Compliance and Privacy Services Department as soon as you discover it by emailing hs-privacyprogram@ucdavis.edu or calling (916) 734-8808. For additional information about breach reporting, please review [UC Davis Health Policy 1302 Protected Health Information \(PHI\)/Personal Information \(PI\) Breach Notification](#).

Research Compliance Program

The Research Compliance Program provides oversight, education, and ongoing support to all areas of UC Davis Health related to clinical research billing, research privacy, and other research regulatory matters to ensure compliance with applicable federal and state laws, regulations and policies. Two major areas of focus for the program are clinical research billing and research privacy. More information about these programs is located on the Compliance Website at:

<http://www.ucdmc.ucdavis.edu/compliance/research/>

Clinical Research Billing (CRB)

Clinical research billing is a critical compliance concern for any academic medical center. The focus of a clinical research billing compliance program is to ensure that research-related clinical costs are directed to the correct payer. In some cases, costs for research-related medical services may be billed to the patient or the patient's insurance. However, insurance cannot be billed when the costs of medical items or services are reimbursed by another source, such as the study sponsor, or when the items or services are provided only for research purposes without therapeutic intent. Some of the safeguards to ensure that research costs are appropriately captured include, but are not limited to:

- Completion of the Medicare Coverage Analysis (MCA) to determine if the research study qualifies to bill routine costs in a clinical trial to Medicare or insurance.
- Completion of a billing grid to identify costs billable to Medicare/insurance or the study account.
- Completion of the Clinical Trials Data Bridge to create a study record and document the MCA.
- Associating research subjects to the study in Epic.
- Associating protocol-directed orders and encounters to the study in Epic.
- Timely completion of Epic research billing review to ensure charges are routed appropriately.

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More information on this process is available in the [UC Davis Health Clinical Research Guidebook](#).

Ensuring appropriate billing of clinical research costs is a complex task, and all research personnel are encouraged to seek training specific to their research responsibilities. The UC Davis Clinical Trials Office offers numerous training opportunities, including CRC 1.0, a foundational course which covers the above topics and more. Additional information is available on their website at:

<http://www.UCDMC.ucdavis.edu/clinicaltrials/Training/training.html>.

Clinical research billing questions can be emailed to: hsresearchcompliance@ou.ad3.ucdavis.edu.

Research Privacy

Federal and state laws, such as the Health Insurance Portability and Accountability Act (HIPAA) and California Medical Information Act (CMIA), as well as UC Davis Health policies and procedures specifically address how protected health information (PHI) can be utilized for research purposes. In general, a patient's medical information may only be accessed for a treatment, payment or operational purpose without obtaining prior written authorization. Access to patient records for most other purposes, including research, requires additional steps to be taken to comply with state and federal privacy laws.

In most instances, the Privacy Rule requires a signed authorization from the individual before access, use or disclosure of PHI for research purposes. Authorization is typically secured by having research subjects sign the [HIPAA Authorization for Research Form](#) at the time of consent. The HIPAA Authorization for Research Form is a separate and distinct form from the study's informed consent form (ICF). Permission to access, use, or disclose PHI for research purposes is not obtained simply by the subject signing the ICF. Access to a patient's record for research purposes must occur in accordance with the protocol, informed consent, and signed authorization.

In limited situations, the Privacy Rule allows an Institutional Review Board (IRB) to waive the requirement for a signed authorization for the use of PHI in research. To obtain a waiver, UC Davis Health's researchers must complete the applicable waiver section of the electronic Initial Review Application when submitting their protocol.

Once conducting the study, accounting of disclosure must be completed by researchers when patient information is accessed for a research purpose under an IRB approved waiver of Authorization. For more information about the privacy rules related to research and instructions for completing accounting disclosures, refer to the [UC Davis Health Clinical Research Guidebook](#). Additional information about the IRB's HIPAA waiver process is available on the UC Davis Office of Research website at <https://research.ucdavis.edu/policiescompliance/irb-admin/researchers/project-guidance/medical-records>

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Coding and Billing Compliance

UC Davis Health is committed to honesty, accuracy and integrity in all patient charging, coding, billing and documentation activities. UC Davis Health workforce members are expected to adhere to the following guidelines when engaging in coding, billing and documentation activities:

- Healthcare services provided must be medically necessary and rendered by qualified healthcare professionals in accordance with the scope of practice and federal and state laws.
- Assignment of CPT, HCPCS, and ICD-10 codes is based on the medical record documentation and payer specific guidelines.
- Medical record documentation must meet the requirements outlined in UC Davis Health Policies [2307](#) and as applicable in Policies [1930](#) and [1905](#).
- With a limited exception, teaching physician services may be billed to Medicare only when the documentation supports that the teaching physician provided a direct service to the patient. See Primary Care Exceptions for E/M Services.

All providers new to UC Davis Health that are seeking billing privileges must complete the mandatory Billing Compliance Training. Completion of this training is mandatory to release charges. A link to the training and additional information for each role can be found on the intranet at <http://intranet.ucdmc.ucdavis.edu/him/etp/etp.shtml>

Documentation/Electronic Medical Record Compliance

Verbal Orders

This section outlines the use of verbal orders as described in [UC Davis Health Policy 4075 Physician Orders](#).

Verbal orders are to be used infrequently and limited to those situations where it is impossible or impractical for the ordering provider to enter an order in the Electronic Medical Record (EMR).

Verbal orders may be used in the following situations:

- When the provider does not have access to the EMR (e.g., when the nurse or allied health professional has initiated a call to the provider requesting an order and the provider reports that they do not have current access to the EMR).
- When the provider is off-site between the hours of 2300 and 0600.
- During a procedure, in which case the order will be entered by appropriate staff and signed by the ordering provider immediately following the procedure.
- In an emergency/urgent situation when it cannot wait for the provider to enter the order.

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- When the issuing provider is participating in teaching rounds (not work rounds).

Verbal orders must not be issued for complex or multiple orders due to patient safety risks. When verbal orders are used, they may only be issued by a licensed or registered physician, NP, PA, or CRNA.

Verbal orders for medication may only be accepted by registered nurses or pharmacists in the inpatient setting. However, in the outpatient setting, verbal orders for medications may be accepted by RNs, LVNs, and pharmacists. Allied health professionals may accept verbal orders specific to their scope of practice

When verbal orders are issued:

- They must be read back to the ordering provider.
- The person accepting the verbal order should enter the order into the EMR and read it back to the ordering provider.
- Leading zeros and decimal points must be vocalized.
- The identity of the ordering provider must also be confirmed by verifying the name and PI number.
- If the recipient of a verbal order cannot reasonably access a computer, the order may be written down on paper, read back to the ordering provider, and later entered into the EMR. In any case, verbal orders are entered into the EMR using “Verbal with read back” as the order mode and the name of the ordering provider who issued it.
- The recipient of a verbal order then electronically signs the order in the EMR, which records the date/time of the order and the recipient’s professional title.

All verbal orders must be cosigned by the ordering provider within 48 hours from the date and time the order was entered. Timely signing of verbal orders is regularly monitored and reported to department chairs. Failure by providers to cosign verbal orders within 48 hours could result in the assessment of a fine against the department of the non-compliant provider. Providers are not required to sign erroneous verbal orders. Refer to Section VI.B. of the policy regarding verbal orders entered in error.

Sharing Notes with Patients

- As of November 2020, UC Davis Health will begin sharing notes broadly across ambulatory, inpatient, and ED for all author types in order to improve transparency with patients, which has been shown to improve patient engagement and may improve adherence to treatment plans. In addition, this will help assure compliance with the 21st Century Cures Act. Other medical information such as Flowsheet and images will need to be shared in 2022.
- While note-writing style generally does not need to change, remember to maintain professionalism: avoid criticizing colleagues or using judgmental language about the patient. Objective facts are usually appropriate to share.

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- If, in your professional judgment, sharing the note would violate the privacy of the patient (e.g., by being viewed by a proxy or if access is coerced) OR sharing might lead to physical or ‘substantial’ harm to the patient, you can un-click the ‘share with patient’ button and use .NOTSHARINGNOTE to document the exclusion you are using to justify the blocking of information.
- If the **patient requests** that the note NOT be shared, you can block sharing as well. This might be relevant if the patient does not want sensitive information visible to proxies. This could be appropriate in abusive situations, adolescent reproductive health, etc.

Sharing Results with Patients

- Federal law also requires sharing results with patients electronically and ‘without delay’.
- State laws do take precedence, so tests on tissues that might show cancer, HIV antibodies, hepatitis antigens, or drug abuse will be delayed for 14 days to allow verbal discussion of the results with the patient.
- If your professional judgement determines that sharing the result might lead to physical or ‘substantial’ harm, you can block the release of the result.
- This is possible in the details of an order before signing it.
- After signing, the ‘MyChart Results Release’ activity will allow control over patients’ visibility of results before or after it is finalized. Document in a note what exclusion is used to justify blocking.

Additional detailed information is available on the [21st Century Cures Act website](#).

Copy and Paste Guidelines

Quality documentation supports patient care, patient and caregiver engagement, continuity of care, record integrity, and accurate coding. As such, [UC Davis Health Policy 2307 Medical Record Documentation Standards](#)—outlines specific guidelines and standards for timely, complete and accurate documentation of healthcare services. The policy also outlines the appropriate use of the copy and paste functionality available in the EMR for all relevant providers including physicians, residents, nurse practitioners, physician assistants, and other documenting providers.

Appropriate use of the EMR copy and paste functionality eliminates duplication of effort and saves time, but it must be used carefully to ensure accurate documentation. Indiscriminate use of copying and pasting may lengthen notes by including unnecessary or redundant information, making it difficult for others to quickly locate pertinent information. It may also result in record inaccuracies. Some guidelines when using copy and paste are:

- Copying forward information should be avoided, especially that which is no longer relevant to the patient’s current condition. Only copy information that remains **accurate and relevant**. It is imperative to appropriately edit any pasted information to assure accuracy.

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- The author is responsible for the accuracy and appropriateness of the information incorporated into their documentation, whether it is copied, pasted, imported, or reused.
- Before adding results and procedures to a note, consider if it will be of use to readers, keeping the fact in mind that information is already available in the chart. Consider a summary and/or interpretation of a test instead. This information leads to ‘note bloat’ and rarely contributes to supporting billing requirements.
- If test results/procedures are copied and pasted into an encounter note, the date of the original test result or procedure should be noted. Information from SmartLinks should be refreshed so the information is up to date.
- Information that should not be copied: a physical exam, assessment and plan from another service; or a medical student’s note.

All entries in the EMR must be patient- and visit-specific, must contain the actual data collected and/or reviewed, and be confirmed by the provider based on medical necessity and personally rendered services. Providers may reference their own prior entries and/or other providers’ entries in the patient’s record (by noting the specific date and time of the referenced entry), such as when the information is pertinent to the reason for the visit, the patient’s history, test or imaging results, etc. Providers should avoid:

- Inappropriate use of copy/paste functionality
- Over-documentation of clinically irrelevant information (not medically necessary)
- Copying redundant information (provided in other parts of the legal medical record)

What is Considered Copy and Paste?

For purposes of this standard, “copy” shall be understood to include: copy/paste, copy forward, imported documentation, “roll-in,” pull-forward, auto-populate features, and any other intent to move documentation from one part of the record to another section of the health record (or to another patient’s record). Cloned documentation refers to medical record documentation that is identical or unreasonably similar to the previous entries for a patient (or another patient’s record)

Some Examples of Inappropriate Copy and Paste:

- Identical entries – Entries that are exactly alike between visits or between providers. The visit note contains the exact same history of present illness, review of systems, physical exam and/or care plan.
- Same patient with identical notes, unchanged from one visit to the next.
- Different patients with identical entries regardless of the patient involved.
- Care team notes that are the same and make it difficult to determine who provided the service, e.g., teaching physician’s note is identical to the house staff note; attending physician’s note is identical to the mid-level provider’s note.

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- Unreasonably similar entries – such as entries that are almost identical to previous entries within an individual’s medical record.

Provider Responsibilities and Good Practices:

- Authenticate notes. Signed notes are “final” and become part of the patient’s legal medical record. Additional information may only be included as an addendum or a new entry. The provider’s signature shall serve as their attestation that the information (whether the content is original or copied) is accurate, and that any copied information is current and represents the provider’s services for that date of service.
- Notes are typically shared with patients when signed/co-signed by attending (inpatient and ED) or when an ambulatory encounter is closed.
- Identify the source of information copied from a prior note (i.e., date, time, prior note’s author). Reconfirm and update as necessary to accurately reflect the care provided during the current encounter.
- Cite and summarize clinically applicable test results (labs, imaging, consult reports, etc.) by date and time, rather than copying the entire report into the current entry.
- Avoid copying one patient’s medical record into a different patient’s medical record.
- Discuss the review of systems (ROS) and past, family and social history (PFSH) with the patient and comment upon pertinent updates to the current encounter, e.g. “ROS and PFSH are unchanged from previous encounter on MM/DD/YYYY” – rather than copying/ pasting the entire ROS and PFSH entry from a previous note. Importing up-to-date content from PFSH-related sections of the EMR is legitimate.
- Use the approved teaching physician documentation template (i.e. SmartText) in the EMR to document teaching physician services, rather than copying the supervisee's note in its entirety.
- Correct errors identified within the documentation in accordance with [UC Davis Health Policy 2307 Medical Record Documentation Standards](#).
- If you are blocking the sharing of a note with patients/caregivers for a reason approved by the regulation, document the relevant exception using the SmartPhrase .NOTSHARINGNOTE in the un-shared note.

General EMR documentation guidelines are available on the Health Information Management (HIM) EMR Training website at:

http://intranet.UCDMC.ucdavis.edu/him/EMR_Train/media/Quality_Clin_Doc/Quality_Clinical_Documentation.pdf

For additional information, please review: [UC Davis Health Policy 2307 Medical Records Documentation Standards](#).

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EMR Downtimes

In addition to predictable quarterly downtimes, we may experience occasional unavailability of EMR access. In order to be prepared, be aware of the resources available:

- **Read-only EMR:** This is an environment that contains recent information about your patients, that is available when Production Epic is down for planned or unplanned downtimes.
- If your location has lost internet connectivity, most departments have at least one **downtime computer**, which contains summary reports for patients on the schedule (ambulatory) or registered for inpatient or ED stays. It may have a battery backup to allow access in power outages.
- The Clinical Resources Center has many downtime forms to help you do your work when EMR is unavailable. Critically, **copies of all order sets** are available for you to print and use to avoid delays of patient care.
- Spend a few moments **before downtimes** to familiarize yourself with these backup systems before they are needed in a chaotic situation.

Teaching Physicians: Billing Reminders and Resource Information on Documentation

- Resident Notes: Teaching physicians must document they performed the service or were physically present during the key/critical portions of the service and may refer to the resident's note for details.
- Medical Student Notes: Teaching physicians may only utilize student documentation when the teaching physician:
 - Was present with the medical student for the exam and the medical decision making;
 - Repeated the examination; and
 - Verified all of the student's documentation.
- Scribes: The use of scribes by UC Davis Health teaching/attending physicians is acceptable if performed in accordance with [UC Davis Health Policy 1930 Scribe Notes](#). The billing provider who has elected to use the services of a scribe is ultimately responsible for the content and accuracy of the scribed note.
- CMS Medicare & Medicaid Services: "Guidelines for Teaching Physicians, Interns, and Residents," <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf> and Office of Inspector General: "Roadmap for New Physicians: Avoiding Medicare & Medicaid Fraud & Abuse," <https://oig.hhs.gov/compliance/physician-education/index.asp>.

General EMR documentation guidelines are available on the Health Information Management (HIM) EMR Training website at:

http://intranet.UCDMC.ucdavis.edu/him/EMR_Train/media/Quality_Clin_Doc/Quality_Clinical_Documentation.pdf

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Questions? Contact the UC Davis Health Compliance Program at 916-734-8808.

Conflict of Commitment and Outside Professional Activities

In accordance with UC Academic Personnel Manuals (APM) 025 and 671, all faculty are subject to earning thresholds and/or time limit for engaging in outside professional activities (OPAs). APM-671 governs faculty members who are members of the health sciences compensation plan and APM-025 governs faculty who are *not* part of the health sciences compensation plan.

OPAs are compensated and uncompensated activities that are within a faculty member's area of professional, academic expertise and that advance or communicate that expertise through interaction with industry, the community or the public. When these OPAs interfere with a faculty member's professional obligations to the University, this is called a conflict of commitment. While engaging in OPAs is allowed, faculty must be mindful of their annual earning thresholds and time limits in order to avoid potential conflicts of commitments. Specifically, APM-671 and APM-025 outline the maximum number of days that faculty may devote to OPAs and the threshold for earned income before a conflict of commitment occurs.

The OPA earning threshold for APM-671 faculty is \$40,000 or 40% of their fiscal-year base salary scale (scale 0), whichever is greater. The annual time limit for these providers is up to 21 days (168 hours) per year or up to 48 days with prior approval. For APM-025 faculty, there is no annual earnings threshold, but they are limited to 48 days of OPAs per fiscal year. Additionally, OPAs are classified into three categories, each with various approval and annual reporting requirements.

- Category I. Real or perceived conflict of commitment because the activity relates to the expertise/training of the faculty member or requires a significant professional commitment. Category I activities require prior approval, but also have specific requirements for time limits, earning thresholds, and annual reporting (i.e., outside teaching, outside research or founding/co-founding a company).
- Category II. Less potential for a conflict of commitment because the activity is generally shorter-term and is outside the course and scope of University employment. Category II activities do not require prior approval, but still have specific requirements for time limits, earning thresholds, and annual reporting (i.e., consulting, expert witness or presenting at a workshop).
- Category III. Unlikely to raise a conflict of commitment because the activity is within the course and scope of University employment (i.e., reviewing manuscripts and presenting talks at academic conferences).

OPAs can also involve activities where the faculty member has academic responsibility for a student. In that case, the faculty member must obtain written approval from the Department Chair before involving

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the student in the OPA. Additionally, the faculty member is responsible for ensuring that the activity does not interfere with the student's academic obligations.

OPAs must be reported annually on a fiscal year basis through the UC Outside Activity Tracking System (OATS). The OATS system can be found at <https://ucdavis.ucoats.org/> and OATS training resources are available at <https://academicaffairs.ucdavis.edu/oats>. For additional information about OPAs review APM-671, APM-025 or contact the Office of Academic Personnel. You can also find additional resources at the links below:

Start-ups, Intellectual Property UC Collaborations

- Office of Innovation and Technology Commercialization
<https://itc.ucdavis.edu>
- Office of Translational Entrepreneurship, School of Medicine
<https://health.ucdavis.edu/medresearch/entrepreneurship/index.html>

Outside Professional Activity Reporting or Conflict of Commitment

- Office of Academic Personnel, Schools of Human Health
<https://health.ucdavis.edu/academicpersonnel/>
- Conflict of Commitment Toolkit:
<https://health.ucdavis.edu/academicpersonnel/administrative-resources/administrators-managers/conflict-commitment/coc-toolkit.html>

Promoting Healthcare Equality

Lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) people often experience stigma, discrimination, and institutional bias in the health care systems which can result in worse health outcomes. Knowing the patient's sexual orientation and gender identity (SOGI) information can reduce these health disparities by helping providers give better, more informed care for LGBTQ patients. UC Davis Health is the first academic health system in the nation to include SOGI as standardized demographic information within the Electronic Medical Record (EMR).



While discussing these issues with patients may be awkward for many of us at first, LGBTQ patients deserve acknowledgement of these aspects of their lives and health. In fact, we do a disservice to our patients if we fail to explore issues of gender and sexuality and how it impacts physical and mental health. Be sure to record this type of information in the chart via the gender/sexuality activity. Data

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captured here can be used to track disparities, enhance care, and increasingly improve clinical decision support tools, such as Storyboard and alerts.

For ten consecutive years, the UC Davis Health has been recognized as a “LGBTQ Healthcare Equality Leader” by the Human Rights Campaign Foundation. This recognition underscores the UC Davis Health’s commitment to providing compassionate and quality care to all patients, regardless of their SOGI. LGBTQ patients, especially transgender patients, will be treated with the same dignity, respect, and quality care as all UC Davis Health patients, in all aspects of the clinical encounter. This policy is consistent with the UC Davis’s guiding principles:

UC Davis Principles of Community

<https://diversity.ucdavis.edu/principles-community>

For more information and questions, please contact:

Vice Chancellor’s LGBTQ+ Advisory Council – <https://health.ucdavis.edu/lgbtq-council/index.html>

Ordering Medical Interpreters for Patients with Limited English Proficiency and Deaf/Hard of Hearing Patients

Trained medical interpreters are available in person, via video and telephone to all Limited English Proficient (LEP) and deaf/hard of hearing patients to facilitate care between patient and provider, including following up with patients at home after procedures. In accordance with current legislative and regulatory requirements, UC Davis Health patients seeking and receiving care will have access to qualified medical interpreters and are not required to bring or provide an interpreter.

Medical interpreters are trained in medical vocabulary, comprehension, retention, and note-taking. They are trained to respect patient confidentiality, pursuant to the Health Insurance Portability and Accountability Act (HIPAA), to honor their own neutral role and work to maintain the integrity of the patient/provider relationship. Therefore, the use of family members as medical interpreters is strongly discouraged. Some patients may prefer to bring or provide an interpreter. In such cases, UC Davis Health will permit patients to do so as long as it does not compromise the quality of patient care services and will document patient’s declination of staff or vendor interpreting services in EMR. UC Davis Health does not reimburse for interpreting services provided by non-UC Davis Health interpreters at the patient’s request. Minors should not serve as interpreters. When scheduling patient appointments, language information shall be captured.

Interpreting services to the deaf/hard of hearing patients are required under the federal Americans with Disabilities Act.

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Refer to [UC Davis Health Policy 2881 Medical Interpreting Services](#)

Medical Interpreting Services Website and Resources:

http://www.UCDMC.ucdavis.edu/interpreting_services/

Controlled Substance Diversion and You

In Calendar Year 2018, there were over 1 million controlled substance Pyxis dispenses in UC Davis Medical Center and Clinics. As the opioid epidemic continues to rise and regulators clamp down on prescribing requirements, hospitals become bigger targets for diversion of controlled substances. Drug diversion is a multifactorial and multidisciplinary issue, particularly involving pharmacy, nursing and medical staff.

To report possible diversion activity, contact one's supervisor, nursing supervisor/manager, pharmacy administration, or call the confidential compliance hotline at 877-384-4272.

Staff should receive regular and timely updates on expected behavior for controlled drug handling, so they are aware if something out of the norm is happening.

The Medication Diversion Oversight Committee (MDOC) developed a competency (DAHS-NGNYRSD17) in mid-2017 to give staff an overview of drug diversion, the signs and symptoms of diversion, and contacts to report known or suspected diversion acts.

- Applicable Policies:
- [UC Davis Health Policy 4091 Automated Dispensing Machine \(ADM\) \(PYXIS\)](#)
- [UC Davis Health Policy 1210 Controlled Substance Accountability for UCDMC Hospital-Based and Primary Care Network \(PCN\) Clinics](#)
- [UC Davis Health Policy 4110 Anesthesia Perioperative Medication Use](#)

Infection Prevention/Control

Tier 1 – Standard Precautions

UC Davis Health mandates the use of Standard and Transmission Based Precautions to protect all healthcare workers and patients from the transmission of infections as recommended by the Centers for Disease Control. The first tier of precautions, or **Standard Precautions**, applies to the care of all patients in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. Standard Precautions include: hand hygiene, use of any personal protective equipment (PPE) (e.g. gloves, gown, mask, eye protection, or face shield) needed to provide care based on anticipated risk, safe injection practices, and respiratory hygiene. PPE must also be considered when handling patients' equipment, linen, care items, and surfaces in the environment to prevent transmission of infectious

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agents (e.g. wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient).

Guidelines for Preventing Transmission of Infections in Healthcare Settings

- Perform Hand Hygiene.
- Use PPE whenever there is a possibility of exposure to infectious material.
- Ensure appropriate patient placement (isolation patients).
- Properly handle, clean and disinfect patient care equipment and instruments/devices. Clean and disinfect the environment appropriately.
- Activate any safety engineered sharp device immediately and discard into Sharps container. Never recap needles on a syringe.

Tier II – Transmission-Based Precautions

In addition to Standard Precautions, Tier II – **Transmission-Based Precautions** are used for patients with documented or suspected infections or colonization with highly transmissible or epidemiologically-important pathogens based on the route of transmission. The transmission-based precautions are as follows:

- **Contact Precautions** for those pathogens spread by direct and indirect contact with the patient or the patient’s environment. **Required PPE:** Standard Precautions in addition to gloves and a gown.
- **Droplet Precautions** for those pathogens spread via droplets within 6 feet. **Required PPE:** Standard Precautions in addition to a mask and eye protection (goggles and face shield).
- **Enhanced Contact/Droplet Precautions** for influenza-like illness, either suspected or confirmed. **Required PPE:** Standard Precautions in addition to a N95 respirator or higher for all direct care and aerosol-generating procedures, eye protection, gloves, and gown.
- **Airborne Precautions** for those pathogens spread by tiny aerosolized particles that are suspended in air for long distances. **Required PPE:** Standard Precautions in addition to a N95 respirator with eye protection (goggles or face shield) or powered air purifying respirator (PAPR) and an Airborne Infection Isolation Room (AIIR).
- **Contact Enteric Precautions** for gastrointestinal bacterial or viral pathogens that are easily spread by direct contact with the patient or the patient’s environment requiring hand washing with soap and water and the use of bleach for equipment and environmental cleaning. **Required PPE:** Standard Precautions in addition to gloves and a gown in addition to bleach cleaning.

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Refer to [UC Davis Health Policy 11025 Standard and Transmission Based Isolation Precautions for Infection Prevention and 11025 Attachment F Standard and Transmission Based Precaution Table for list of diseases requiring precautions.](#)

Airborne or Aerosol Transmissible Diseases (ATD)

The Aerosol Transmissible Diseases Plan is found in the UC Davis Health Policy [UC Davis Health Policy 2002 Aerosol Transmissible Disease Control Plan, which covers the regulatory text of the CAL/OSHA ATD Standard \(Title 8, CCR Sections 5199\)](#). This policy applies to all diseases transmitted via the airborne route and requires either Airborne Precautions (i.e., pulmonary tuberculosis [TB], measles) or Droplet Precautions (i.e., influenza, pertussis). Identify suspected symptomatic patients early and appropriately isolate immediately to prevent unprotected exposure.

Exposures to patients with an ATD: If Infection Prevention determines that an exposure of a healthcare worker has occurred then Infection Prevention will notify the manager. The manager will prepare a list of exposed employees based on the exposure criteria and send the list to EHS. EHS will provide treatment and all follow-ups as indicated. Employees may also report exposures directly to EHS.

Environmental Services staff can clean the room while wearing a PAPR or N95 mask during this rest hour.

A PAPR is worn when performing a high hazard procedure (aerosol generating procedure) on Airborne (i.e., TB patient) or Droplet precaution patient (i.e., influenza). High hazard procedures (listed in the ATD Plan) include: bronchoscopy, open suctioning, sputum induction, aerosolized administration of pentamidine or other medications, pulmonary function testing, and procedures in autopsy, surgery, or laboratory that may aerosolize pathogens.

Engineering Controls: AIIR are equipped with negative air pressure; air in patient room is vented directly outdoors with a minimum of 12 air exchanges per hour. HEPA filtration may be used as adjuncts to engineering controls. AIIR doors must be closed at all times while in use. Audible alarms sound when the door is left open to the room or anteroom.

Work Practice Controls: Prompt triage of patients so isolation is important. Follow hand washing policies. Wear a correctly sized respirator. Keep doors to patient room closed.

UCDMC established a Respiratory Protection Policy to protect employees from airborne exposures to hazardous materials and biological agents that cannot be consistently controlled by work practices and/or engineering controls. All departments shall identify employees' need to wear respiratory protection and ensure that it is worn when required. For N95 and elastomeric masks, fit testing must be performed annually (refer to [UC Davis Health Policy 1603 Respiratory Protection Program](#)).

Personal Protective Equipment: The Aerosol Transmissible Diseases Plan mandates the use of a NIOSH approved respirator such as N95 or elastomeric respirator or a PAPR for protection against AirIDs. UC

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Davis Health workforce must be fit tested to wear a N95 or trained to use a PAPR. PAPRs are also used for healthcare workers who have facial hair (prevents a N95 masks from properly sealing) and for use with high hazard procedures. Wear the respirator when going into a TB/AirID or other airborne pathogen patient's room, performing cough-inducing procedures, during patient transport, or while working on a ventilation system that may contain airborne pathogens. Gloves and gowns are worn to keep respiratory secretions away from clothing and skin. Dispose of PPE according to hospital policy.

Vaccination: All healthcare workers are required to participate in the annual [influenza](#) vaccination and provided the immunization free of charge. For more information of influenza, efficacy, safety, method of administration, the benefits of being vaccinated see [vaccination information sheet](#). For a list of other free vaccinations please EHS.

Control of Tuberculosis

Tuberculosis is a disease caused by *mycobacterium tuberculosis* which is often spread via airborne transmission. In most individuals, *mycobacterium tuberculosis* is contained by the host immune system, which is referred to as latent TB infection (LTBI). These individuals are asymptomatic and non-infectious. However, latent infection has the potential to develop into symptomatic infection (active TB) at any stage in life, which is potentially life-threatening and also easily spread to others via airborne particles.

Active TB is usually marked by pulmonary/respiratory symptoms as that is the primary located on *mycobacterium tuberculosis* infection in the body. Common symptoms include fever, cough (including bloody cough), shortness of breath, unintended weight loss and night sweats.

Environmental controls to prevent transmission of active tuberculosis are discussed above. Employee screening, education and treatment also play a large role in preventing the spread and development of active tuberculosis. All employees are screened for latent tuberculosis at-hire, usually with interferon-gamma release assay (IGRA) blood tests, though sometimes tuberculin skin tests are placed instead. If an employee who tests positive for LTBI at hire has not taken any medications for LTBI, it is very important for them to watch for the symptoms of active tuberculosis as noted above. For these employees, it is important to complete an annual symptom review which will be administered by Employee Health Services to ensure that there is no sign of progression to active tuberculosis.

Employees with LTBI and risk factors for progression/re-activation include those with immunosuppression, including HIV, organ transplant, biologic medications, steroids or other treatments/conditions that weaken the immune system. If an employee with LTBI is interested in getting treatment in order to reduce the chance of progression to active TB by up to 90%, they can contact Employee Health Services to discuss treatment options.

For employees who did not test positive for LTBI at-hire, it is important to be aware of risk factors for coming into contact with *mycobacterium tuberculosis*. These include spending more than 30 days in a country with high rates of TB, which includes all countries except those in Western Europe, Northern Europe, Canada, Australia and New Zealand. This also includes having close contact with anyone who

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has had active TB (both at work and in the community). Finally, it also includes time spent in a facility where TB is common, such as jail/prison, homeless shelters or working in a health care facility in a country with high rates of TB. Employees without a history of LTBI who have any of these risk factors may contact Employee Health Services for voluntary TB testing to screen for LTBI. Employees should also report any exposure to active TB at work so they can have post-exposure testing and treatment if necessary.

Multidrug Resistant Organisms

Multi-Drug Resistant Organisms (MDRO): MDROs are resistant to classes of antibiotics making them difficult to treat as well as a danger for transmitting infections in the hospital/community. Contact Isolation precautions may be required with specific MDROs such as Carbapenemase Resistant Enterobacteriaceae-(CRE), extended beta-lactamase producing organisms (ESBL). See [UC Davis Health Policy 11025 Attachment F Standard and Transmission Based Precaution Table](#) for a list of diseases requiring Standard or Transmission based precautions.

Methicillin Resistant *Staphylococcus Aureus* (MRSA)

Staphylococcus aureus (SA) is a pathogen that commonly causes infections in humans. MRSA is a variety of SA that has developed resistance to the common antibiotics used to treat SA infections. Important elements of the MRSA Control Program are as follows:

- Antimicrobial Stewardship Program to control the use of antibiotics.
- A daily bath treatment with CHG (chlorhexidine gluconate) for all eligible patients is required to reduce the number of organisms (including MRSA) on patients' skin.
- Careful and frequent cleaning/disinfection of the patient's environment which includes the patient's room and all equipment used by the patient.

As mandated by California Senate Bill 1058 (Nile's Law), an anterior nares swab will continue to be obtained on each patient admitted looking for the presence of MRSA. Nurses are required to educate patients about MRSA and document this education in the EMR Patient Education Record. A MRSA brochure is available for patient education in multiple languages. Physicians are required to notify their patients of positive MRSA results.

MRSA information is available on the Infection Prevention web page:

<http://intranet.ucdmc.ucdavis.edu/infectioncontrol/>

Refer to [UC Davis Health Policy 11012 Methicillin/Oxacillin-Resistant *Staphylococcus aureus* \(MRSA\) Patient](#).

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NOTE: Vancomycin Resistant Enterococcus (VRE) and MRSA patients are no longer routinely placed in Contact Precautions unless the patient has an infection which has copious respiratory secretions or purulent wound drainage that cannot be contained in a dressing.

Bloodborne Pathogens Exposure Control Plan (Hepatitis B, C, and HIV)

The UC Davis Health Bloodborne Pathogens Exposure Control Plan is located in [UC Davis Health Policy 2001](#) and lists safety measures for preventing exposures to bloodborne pathogens such as Hepatitis B virus (HBV), Hepatitis C virus (HCV), and Human Immunodeficiency Virus (HIV) which can cause severe disease and death. These pathogens are transmitted through contact with body fluids infected with the viruses, such as blood, semen, vaginal fluid, or any body fluids with blood present. OSHA and the UC Davis Health Bloodborne Pathogen Exposure Control Plan ([UC Davis Health Policy 2001](#)) require prevention strategies to be followed to avoid contact with bloodborne pathogens in blood and other potential infectious material. The use of PPE (face shield, mask, goggles, gloves, and gowns), safety devices, and activation of the safety feature of sharps to prevent sharp injuries are required prevention activities.

NOTE: Lab coats and uniforms (scrubs) do NOT qualify as PPE because they are not impervious to fluids and cannot prevent direct contact with blood/body fluids. Regular eyeglasses will not protect eyes from a splash exposure. Safety goggles/face shields should be worn as appropriate to prevent splash exposures.

Sharp Safety- Needle Resistant Glove Education

Needle Resistant Gloves are necessary to prevent needle or sharp injuries when searching all patient property.

Gloves must be the appropriate size. Please use the Glove Sizing Guide when measuring hand to identify glove size. Clean Needle Resistant Gloves will be checked daily to ensure three pairs of small/medium/large are available. These gloves are only for staff who were not issued Needle Resistant Gloves. Notify Charge Nurse if no Needle Resistant Gloves available.

Steps to Don Needle Resistant Gloves

1. Perform hand hygiene.
2. Select the appropriately sized nitrile exam gloves.
3. Hold with one hand and insert the other. When the base of your thumb reaches the cuff of the glove begin to spread fingers and insert hand into glove.
4. Pull glove cuff towards wrist to cover as much skin as possible and secure glove.
5. Check to make sure there are no holes or tears.
6. Select appropriate size needle resistant gloves

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7. Hold with one hand and insert the other. When the base of your thumb reaches the cuff of the glove begin to spread fingers and insert hand into glove.
8. Pull glove cuff towards wrist to cover as much skin as possible and secure glove.
9. Check to make sure there are no holes or tears.

5 Steps to Doff Needle Resistant Gloves

1. First remove one needle resistant glove by pulling away from your body.
2. While still wearing the nitrile glove remove other needle resistant glove by pulling away from your body.
3. Place Needle Resistant Gloves in designated bin and wash hands before touching any other surfaces.
4. If the gloves were damaged or significantly soiled by blood/bodily fluids, place gloves in bin marked dirty/damage.
5. Used gloves will be inspected weekly for damage and cleaned prior to being placed on the unit.

Reporting Blood or Body Fluid Exposures

An exposure to blood or body fluid occurs when UC Davis Health workforce receive a needle stick, puncture wound, or cut from any object contaminated with another person's blood or body fluid. An exposure occurs when patient's blood or body fluid comes into contact with an open wound, non-intact skin, or mucous membrane (eye, nose, and mouth).

If UC Davis Health workforce sustains a blood/body fluid exposure, Employee Health Services will provide treatment and all follow-ups as indicated.

1. First aid: Irrigate the contamination/wound site with water for 3 to 5 minutes. Do not squeeze or scrub the area. Do not go to the Emergency Department for treatment after sustaining an exposure unless there is also an injury that warrants ED care.
2. Report: UC Davis Health workforce is responsible to report exposures to Employee Health Services and fill out the incident report online by typing "employeeexposure" as one word in the intranet browser's address bar by clicking onto the "EE" icon located on your computer desktop or accessing through the Employee Health webpage. The source patient lab slip is generated through this website. Health care worker follow-up labs coordinated through Employee Health Services. Paper exposure report forms are to be used by pre-hospital personnel, which is coordinated by the Emergency Department.

NOTE: Do not use RL Solutions (RLDatix) incident reporting system.

3. Call: Call Employee Health Bloodborne pathogen phone line at 916-734-7585 to report personal exposure after having completed the exposure online. Leave a voicemail message if no one answers or if after hours. For after-hours high-risk exposure (known HIV + exposure) inquiries, call the Infectious Disease Fellow on-call.

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- a. An Employee Health Nurse will contact the exposed employee with the initial source patient lab results of the rapid HIV. After hours, the nursing supervisor or Infectious Disease Fellow will contact the employee with results. The Employee Health Nurse will also call when all source patient labs are completed to discuss a follow up plan.
- b. All direct care providers are offered Hepatitis B vaccination at no cost. Currently there is no vaccine available for Hepatitis C.

Refer to [UC Davis Health Policy 2167 Blood/Body Fluid Exposure \(Needlestick\)](#) for the procedure to follow in case of accidental contamination with blood/body fluids.

Antibiotic Stewardship

The prompt initiation of antibiotics to treat infections has been shown to reduce morbidity and save lives. However, 30 - 50% of antibiotics prescribed in U.S. hospitals are inappropriate or unnecessary. This has resulted in the development of multi-drug resistant organisms, which has become an ever-increasing problem. These organisms have made it difficult to treat infections effectively. They have also increased antibiotic usage such that this has become a major public health issue. Overuse of antibiotics also contribute to increasing problems with *Clostridioides difficile* infections. Therefore, optimizing the use of antibiotics is important to patient safety and has become a national priority.

For healthcare providers, it is important to:

1. Be notified immediately when the laboratory identifies drug-resistant infections in the patients.
 - a. Use Antibiogram to know what patient drug-resistant infections are present in the facility
 - b. Prescribe antibiotics wisely, which includes, but is not limited to:
 - i. Using the correct drug for as short a duration as possible
 - ii. Using antibiotic “time outs,” which prompts a reassessment of the continuing need and choice of antibiotics when the clinical picture is clearer and more diagnostic information is available.
 - iii. Remove temporary medical devices such as catheters and ventilators as soon as they are no longer needed

Healthcare-Associated Infections (HAI)

Clostridioides difficile

(also known as “C. diff,” formerly called *Clostridium difficile*)

In the United States in 2015, there were about half a million infections caused by *Clostridium difficile* (*C. difficile*, a spore-forming organism) and 15,000 patient deaths. Patients with *C. difficile* infection (CDI) can experience recurrent infections. Active CDI patients may have diarrhea, fever and abdominal pain, loss of appetite and nausea. CDI is transmitted by contact with contaminated surfaces, hands of healthcare workers or ingestion of *C. difficile* spores which are present in both symptomatic and

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asymptomatic patients. The risk for CDI increases in patients with antibiotic exposure, proton pump inhibitors, gastrointestinal surgery/manipulation, long length of stay in healthcare settings, a serious underlying illness, immunocompromising conditions and/or advanced age. However, there are increasing numbers of CDI being reported in low risk people such as healthy individuals in the community with no exposure to healthcare settings.

Basic steps to prevent CDI are:

- Use antibiotics judiciously. UC Davis Health has an active antibiotic stewardship program available to seek advice regarding antibiotic prescribing.
- Early identification and isolation for patients with known or suspected CDI: Use the CDI testing algorithm per [UC Davis Health Policy 11033 Testing and Infection Prevention for Patients with *Clostridium difficile*](#) for appropriate specimen collection and testing for CDI. Symptomatic patients are placed in Contact Enteric Precautions immediately, pending test results.
- Hand Hygiene: Strict hand hygiene with soap and water is required as waterless alcohol hand hygiene products do not kill *C. difficile* spores.
- Cleaning: Thorough cleaning and disinfection of all environmental surfaces and reusable equipment is critical. At UC Davis Health, a two-step cleaning process is used with the first step performed with a hospital-approved disinfectant to clean and remove any obvious contamination and *C. difficile* spores on surfaces. The second step is performed using a hospital-approved bleach product to both physically remove and kill any remaining spores that may be left behind after the initial step.
- Notification of CDI to receiving facilities: If CDI patients are transferred to other facilities; ensure that appropriate history and treatment information is reported to the receiving facility.

Device-related Infections

Current healthcare practices use many types of invasive devices and procedures to treat patients which can put patients at risk for infections. These healthcare-associated infections (HAIs) include central line-associated bloodstream infections (CLABSIs), catheter-associated urinary tract infections (CAUTIs), and ventilator-associated pneumonia (VAP). To prevent device related infections, UC Davis Health uses “prevention bundles” that are supported by evidence-based practice and have been found to be effective in preventing infection. The two most important points to remember are to utilize devices only when absolutely necessary, and to remove all devices as soon as they are no longer needed.

Hand Hygiene

According to the Centers for Disease Control and Prevention (CDC) hand hygiene is the single most important procedure for preventing healthcare acquired infections by reducing the carriage of potential pathogens on the hands. All healthcare personnel and visitors must use strict hand hygiene to prevent cross-transmission between patients, equipment and environment. Use of hospital approved lotions and creams can prevent dryness from frequent hand hygiene.

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The [World Health Organization](#) promotes hand hygiene using the “Five Moments of Hand Hygiene” campaign. There are five key moments in healthcare when employees should wash their hands:

1. Before touching a patient
2. Before clean/aseptic procedures
3. After body fluid exposure/risk
4. After touching a patient, and
5. After touching patient surroundings

Use an Alcohol-Based Hand Sanitizer (Rub hands vigorously for 20 seconds)	Wash with Soap and Water (Rub hands vigorously for 15 Seconds)
<ul style="list-style-type: none"> • Upon entrance to a patient room. • After glove use • Immediately before touching a patient • Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices • Before moving from work on a soiled body site to a clean body site on the same patient • After touching a patient or the patient’s immediate environment 	<ul style="list-style-type: none"> • When hands are visibly soiled • After caring for a person with known or suspected infectious diarrhea • After known or suspected exposure to spores (e.g. <i>B. anthracis</i>, <i>C. difficile</i> outbreaks) • Following glove removal if transdermal medications were handled (refer to UC Davis Health Policy 4039)

For more information, please visit the hand hygiene webpage by typing “hands” into the Intranet URL or refer to [UC Davis Health Policy 11023 Hand Hygiene](#).

Surgical hand scrub: using anti-microbial soap or detergent preparation and water with brush to achieve friction for at least 120 seconds to remove or destroy transient microorganisms and reduce resident flora.

Nails should be short and clean. Nail polish should not be chipped. Artificial nails are more likely than natural nails to harbor pathogens that can lead to healthcare acquired infections. Therefore, artificial nails and nail tips are prohibited for all healthcare personnel providing hands-on patient care.

To Glove or Not to Glove?

Appropriate glove use is well-supported by evidence-based science.

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- Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur.
- Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment.
- Perform hand hygiene immediately after removing gloves.
- Change gloves and perform hand hygiene during patient care if gloves become damaged:
 - a. gloves become visibly soiled with blood or body fluids following a task,
 - b. moving from work on a soiled body site to a clean body site on the same patient, or
 - c. if another clinical indication for hand hygiene occurs.
- Never wear the same pair of gloves in the care of more than one patient.
- Carefully remove gloves to prevent hand contamination.
- Gloves should be worn during patient transport when an employee anticipates contact with body fluids or open wounds.

For example, it is appropriate to wear gloves to transport a trauma patient who is bleeding or using a resuscitation bag on a patient during transport. It is appropriate to wear gloves during transport of a patient with burns (sterile gloves should be worn if burns will be touched). For all other circumstances, it is inappropriate to wear gloves during patient transport. When transporting a patient who will need care and requires isolation precautions, there must be an additional transporter who is not wearing isolation garb; this person may touch the environment (elevator buttons, door handles, etc.). All transporters wearing isolation garb must avoid touching the hospital environment while transporting the patient in order to protect patients, visitors and other hospital personnel. Refer to [UC Davis Health Policy 11021 Transportation of Patient with Communicable Infection](#).

Protecting visitors, other patients, and healthcare workers means gloves are not used to touch elevator buttons, or opening doors. Visitors touch buttons on elevators, doors and door handles. It is inappropriate for staff (MDs, RNs, transporters, environmental services) to wear gloves while touching these items.

Agents of Chemical and Bioterrorism

Staff should be aware of the possible unconventional threats such as those caused by a chemical or biological attack. An act of terrorism may occur as a covert or announced event. Allowing a patient into UC Davis Health facilities without recognizing the potential threat can create delays in treatment,

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detection, containment, and may expose other UC Davis staff and patients to the dangers associated with CBRE.

Chlorine

Chlorine in some cases can be readily identifiable from a pungent well-recognized odor and a green yellowish cloud. It will likely be in a gaseous state and travel downhill and remain close to the ground. When chlorine interacts with water found in the mucus membranes it will form hydrochloric acid. Some of the signs and symptoms include irritation of the eyes, nose, and throat, causing coughing, laryngospasm, and bronchospasms.

Phosgene

This chemical was introduced in World War I. Today phosgene is widely used in the production of polyurethanes and pesticides. Phosgene is a highly toxic gas and is colorless with a relatively innocuous odor. Some has said that there is an odor of mown hay or grass. Exposure to low concentrations of phosgene can produce mild cough, chest discomfort, and dyspnea. High concentrations may produce pulmonary edema, severe cough, dyspnea, laryngospasm, and frothy sputum.

Anhydrous Ammonia

Ammonia is highly water soluble with a pungent odor. Ammonia is a severe eye irritant and respiratory hazard. Ammonia in gas form may look like a white fog cloud. The strong alkali reacts with mucus membranes and can cause burns to the skin, cornea, and respiratory tract.

Methyl Isocyanate (MIC)

MIC is what killed thousands of people in Bhopal India in 1984. MIC is used in the production of synthetic rubber, adhesives, pesticides, and herbicides. It is extremely toxic by inhalation, ingestion, and skin absorption. Inhalation can cause cough, dizziness, shortness of breath, sore throat and unconsciousness. MIC is corrosive to the skin and eyes. Short term exposure can lead to pulmonary edema, bronchitis, and bronchial pneumonia.

Cyanide

Cyanide is widely used in US industry and research laboratories. Cyanide is capable of causing mass casualties if released in an enclosed space such as a concert hall, movie theatre, or sports arena. Cyanide poisons cells and causes oxygen deprivation on the heart and brain. Early symptoms of acute cyanide exposure include neurological manifestations such as giddiness, confusion, headache, dizziness, nausea and vomiting, eye irritation, hyperventilation, and shortness of breath. Death can occur within minutes depending on the amount and type of exposure.

Anthrax

Anthrax is caused by *Bacillus anthracis*. Humans usually become infected by contact with contaminated animals. Person to person transmission of inhalational disease does not occur naturally. Direct exposure

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to vesicle secretions of cutaneous anthrax lesions may result in secondary cutaneous infection, but not pulmonary infection. Pulmonary anthrax is associated with bioterrorist caused exposure to aerosolized spores. The incubation period is 1-8 weeks. Standard precautions are used in the hospital.

Botulism

Clostridium botulinum produces a potent neurotoxin, botulinum toxin. This toxin inhibits the release of acetylcholine, resulting in flaccid paralysis. Botulinum toxin exposure may occur following exposures to contaminated food or air. Standard precautions are implemented. A vaccine is available as an investigational drug.

Plague

Plague is caused by *Yersinia pestis*, which is transmitted by infected fleas. A bioterrorism-related outbreak by airborne means can cause a pulmonary variant called pneumonic plague. Person-to-person transmission is possible via large droplets. Droplet precautions are implemented until the patient has had 72 hours of effective antimicrobial treatment.

Smallpox

Smallpox is caused by the variola virus. A single case is considered a public health emergency. It can be transmitted via the airborne route. The incubation period is 7-17 days. Patients are infectious at the onset of the rash and remain infectious until the scabs separate (3 weeks). A vaccine is available, but it does not confer lifetime immunity. Previously vaccinated persons are considered susceptible to smallpox. Isolation procedures include standard precautions plus airborne and contact precautions. Healthcare workers wear respiratory protection when entering the patient's room.

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Appendices

Appendix A: 2021 National Patient Safety Goals

The Joint Commission introduced the National Patient Safety Goal program in 2002 to reinforce the need for organizations to promote specific improvements in patient safety planning. The emphasis is on assessing, managing, monitoring, improving and reporting patient safety related information and data.

UC Davis Health has a strong, fundamental commitment to providing the highest level of safe, quality patient care. Why patient safety? “It’s important, it’s our business and it’s because we care.” Staff can access the internet site, Joint Commission Resources, which covers current hot issues from Universal Protocol to Medication Management and Continuous Survey Readiness.

[Note: Joint Commission has established the numbering system. Some goals and/or requirements have been retired, converted to standards, or are not applicable to the hospital setting.]

The goals are:

Goal #1: Improve the Accuracy of Patient Identification

NPSG.01.01.01 Use at least two patient identifiers when providing care, treatment, and services. ([UC Davis Health Policy 2702 Patient Identification and Safety Bands for the Hospitalized Patient](#)), III.D.1). Before any procedure is carried out, the identification band shall be on the patient and will be checked for the following two identifiers to ensure that the correct patient is involved: a. patient name, b. patient medical record number.

Label containers used for blood and other specimens in the presence of the patient.

Use distinct methods of identification for newborn patients. Note: Examples of methods to prevent misidentification may include the following:

- Distinct naming systems could include using the mother’s first and last names and the newborn’s gender (for example, “Smith, Judy Girl” or “Smith, Judy Girl A” and “Smith, Judy Girl B” for multiples).
- Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification).
- Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).

*NPSG 01.03.01 – moved from NPSG section to standards section

Goal #2: Improve the Effectiveness of Communication Among Caregivers

NPSG.02.03.01 Report critical results of tests and diagnostic procedures on a timely basis:

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([UC Davis Health Policy 2720 Communicating Critical Lab Values](#); [Radiology P & P 410 Radiology Exam Priorities](#))

Goal #3: Improve the Safety of Using Medications

NPSG.03.04.01 Label all medications, medication containers (e.g., syringes, medicine cups, basins, etc.), and other solutions on and off the sterile field in perioperative and other procedural settings:

([UC Davis Health Policy 3091 Labeling of Medications in Perioperative & Procedural Areas](#))

NPSG.03.05.01 Reduce the likelihood of patient harm with the use of anticoagulation therapy:

([UC Davis Health Policy 4064 Anticoagulation Management Program](#); [UC Davis Health Policy 13011 Heparin Infusion, Low Molecular Weight Heparin, Fondaparinux, Direct Thrombin Inhibitors or Oral Direct Factor Xa Antagonists for Prevention or Treatment of Thromboembolism](#))

NPSG.03.06.01 Maintain and communicate accurate patient medication information: obtain medication information, document and compare to resolve discrepancies, provide written information and education to the patient at discharge or end of encounter.

([UC Davis Health Policy 2711 Medication Reconciliation](#); [UC Davis Health Policy 4080 Prescription Medications Following Discharge](#); [UC Davis Health Policy 4085 Management of a Patient's Own Home Medications Brought into UCDMC](#))

Goal #6: Reduce the Harm Associated With Clinical Alarm Systems

NPSG.06.01.01 Improve the safety of clinical alarm systems:

([UC Davis Health Policy 1467 Safe Medical Device Act \(SMDA\) Guidelines](#); [UC Davis Health Policy 2263 Safe Medical Device Act Device Tracking](#); [UC Davis Health Policy 1639 Patient Care Equipment Training](#); [UC Davis Health Policy 2242 Equipment in Patient Care Areas](#))

Goal #7: Reduce the Risk of Healthcare-Associated Infections

NPSG.07.01.01 Comply with either the current [World Health Organization \(WHO\)](#) or [Centers for Disease Control and Prevention \(CDC\)](#) hand hygiene guidelines: [UC Davis Health Policy 11023 Hand Hygiene](#))

*NPSG 07.03.01 – moved from NPSG section to the standards section

*NPSG 07.04.01 - moved from NPSG section to the standards section

*NPSG 07.05.01 - moved from NPSG section to the standards section

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*NPSG 07.06.01 - moved from NPSG section to the standards section

Goal #15: The Hospital Identifies Safety Risks Inherent in its Patient Population

NPSG.15.01.01 Reduce the risk for suicide: A risk assessment is conducted on patients to determine if they are at risk for suicide. Community resources and a crisis hotline should be provided to the patient and their family members.

[\(UC Davis Health Policy 4072 Observation of the Suicidal, Agitated, Behaviorally Difficult, and High Safety Risk Hospitalized Patient\)](#)

Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

The Universal Protocol applies to all surgical and nonsurgical invasive procedures. Evidence indicates that procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation, although other procedures may also affect patient safety. Hospitals can enhance safety by correctly identifying the patient, the appropriate procedure, and the correct site of the procedure.

The Universal Protocol is based on the following principles:

- Wrong-person, wrong-site, and wrong-procedure surgery can and must be prevented.
- A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site.
- Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.
- To the extent possible, the patient and, as needed, the family are involved in the process.
- Consistent implementation of a standardized protocol is most effective in achieving safety.

UP.01.01.01 Conduct a Pre-procedure Verification Process: Implement a pre-procedure verification process to verify the correct procedure, for the correct patient at the correct site.

UP.01.02.01 Mark the Procedure Site: The procedure site is to be marked with as much involvement by an awake/aware patient as possible.

UP.01.03.01 A Time-Out (Surgical Pause) is Performed before the Procedure: Immediately PRIOR to skin incision, the entire team will actively participate in a time-out during which key information regarding the surgery/procedure and patient will be verified.

[UC Davis Health Policy 4019 Universal Protocol](#)

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Appendix B: UC Davis Health Code of Conduct Standards

Standard 1 — Quality of Care

The university's academic health centers and health systems will provide quality healthcare in a manner that is appropriate, medically necessary, and efficient.

1. All patients will be afforded quality clinical services.
2. Urgent and/or medically necessary services will be provided independent of payment methodology. The University's healthcare professionals will follow current medical and ethical standards regarding physicians' and other healthcare providers' communication with patients, and where appropriate, their representative, regarding the care delivered.
3. The University recognizes the right of patients to make choices about their own care, including the right to do without recommended care or to refuse treatment.
4. University personnel, generally the patient's healthcare providers will inform patients about the alternatives and risks associated with the care they are seeking and obtain informed consent. To the extent possible, this information will be provided in a language that the patient can understand.

Standard 2 — Medical Necessity and Appropriate Services

The University's academic health centers and health systems shall submit claims for payment to government, private, or individual payers for those services or items that are medically necessary and appropriate.

1. When ordering or providing services or items, University physicians (or other healthcare professionals authorized by law to order items or services) shall only order those services and items that are consistent with generally accepted medical standards for diagnosis or treatment of disease and are determined by the profession to be medically necessary and appropriate.
2. In some cases, a healthcare professional may determine that services are medically necessary or appropriate, but the patient's health plan may not cover those services. In those cases, a patient should refer to their health plan administrator to receive information about the process for disallowed claims or uncovered benefits.
3. Patients may request services that are not covered benefits. Such services may be provided as long as the patient has been given advance notice and has agreed to pay for the services. In these cases, the patient may request the submission of a claim for the services to protect their appeal rights with respect to those services or to determine the extent of the coverage provided by the payer.
4. Professional coding and documentation will be consistent with the standards established in the University and Campus Programs and relevant policies.

Standard 3 — Proper Coding, Billing, and Patient Accounting

University personnel involved in the coding, billing, documentation and accounting for patient care services for the purpose of billing government, private or individual payers must comply with all

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applicable state and federal regulations and campus policies and procedures for detecting and preventing fraud, waste, and abuse.

1. The University will bill only for services actually rendered and shall seek the amount to which the University is entitled. The University does not tolerate billing practices that misrepresent the services actually rendered.
2. Supporting medical documentation must be prepared for all services rendered. University personnel shall bill on the principle that if the appropriate and required documentation has not been provided, then the service has not been rendered.
3. All services must be accurately and completely coded and submitted to the appropriate payer in accordance with applicable regulations, laws, and contracts and campus policies and procedures. In all cases, federal and state regulations take precedence; however, campus policies and procedures must accurately reflect those regulations.
4. All patients shall be consistently and uniformly charged. Discounts will be appropriately reported, and items and services consistently described so that comparability can be established among payers.
5. Government-sponsored payers shall not be charged in excess of the provider's usual charges. Any questions regarding the interpretation of this standard should be directed to the chief compliance officer or university legal counsel.
6. Billing and collections will be recorded in the appropriate accounts. Credit balances must be processed in a timely manner in accordance with applicable rules and regulations. When the cost report process identifies any credit balances, University personnel shall direct those issues to the academic health center, the health system's accounting or risk management departments, or other personnel responsible for patient accounts.
7. University personnel should be aware of the existence of system-wide and campus Professional Fee Billing Guidelines and Clinical Laboratory Billing Guidelines. These Guidelines, available through the campus Compliance Office, provide for the policies and procedures to be followed when the University bills payers for professional fees and laboratory services. University personnel responsible for coding, billing, and documentation should be knowledgeable about University policies and procedures, and federal and state regulations regarding those activities. The University shall provide these individuals with opportunities for training to allow them to accurately code, document, and bill according to federal and state regulations and the University's policies and procedures. Management at each academic health center campus should ensure that appropriate evaluation processes have been established to assess whether University personnel understand and carry out correct procedures.
8. Elective procedures that are not covered by governmental or private payer can be provided. However, before providing any elective services, the provider must inform the patient that these services may not be covered. The provider should obtain the patient's agreement to pay for the

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services if payers deny the claim. A patient has the right to have a claim submitted even if services are excluded from coverage.

9. An accurate and timely billing structure and medical records system is critical to ensure that University personnel can effectively implement and comply with required policies and procedures. Demonstrated lapses in the information and billing systems infrastructure should be remedied in a timely manner by the campus executive management team, other designated University personnel and billing entities.

Standard 4 — Proper Cost Reporting

University personnel who are responsible for the preparation and submission of cost reports must ensure that all such reports submitted to government and private payers are properly prepared and documented according to all applicable federal and state laws.

1. In submitting and preparing cost reports, all costs will be properly classified, allocated to the correct cost centers, and supported by verifiable and auditable data.
2. It is the University's policy to correct any cost report preparation or submission errors and mistakes in a timely manner and, if necessary, clarify procedures and educate employees to prevent or minimize recurrence of those errors.

Standard 5 — Respect of Confidentiality

All efforts will be made to protect personal and confidential or privileged information concerning the academic health center and health system's patients and the respective healthcare practices of those entities. University personnel will abide by applicable state and federal laws, including HIPAA privacy and security regulations.

1. University personnel shall not disclose confidential patient information unless authorized by the patient and/or when authorized by law. Approval for appropriate use of patient information for research purposes must be obtained from the Institutional Review Board.
2. Confidential patient information should only be discussed with or disclosed to appropriate University personnel as permitted by HIPAA policies.
3. Confidential patient information should not be discussed with or disclosed to non-University personnel unless authorized by the patient or permitted by law. Non-University personnel include the family or business and social acquaintances of the patient or of University personnel, customers, suppliers, or others.
4. In general, patients can request and are entitled to receive copies or summaries of their records with the exception of non-emancipated minors, some mental health patients, and patients being treated for alcohol and drug abuse, who may be provided with copies of the records if it is appropriate as judged by their clinician.
5. Some information may be sought under the California Public Records Act, the Information Practices Act, or other statutes requiring the release of information.

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6. University personnel who have any questions regarding patient confidentiality should refer to University policies for additional information and consult with appropriate supervisor, manager, the Compliance Office, or the Privacy Officer.
7. University personnel shall not reveal or disclose confidential medical staff or peer review information. California and federal law bestow certain privileges and provides for confidentiality of certain records, including the proceedings and records or organized committees of the medical staff and peer review bodies.
8. University personnel shall not reveal or disclose proprietary or trade secret information to unauthorized non-University persons. Proprietary information may relate to University business affairs or the affairs of a vendor or contractor.
9. Personnel records are considered confidential. Access to personnel files is limited to management, the human resources department staff, and internal auditors, and these individuals are held accountable for protecting the privacy of personnel records.

Standard 6 — Creation and Retention of Accurate Patient and Institutional Records

All patient and institutional records are the property of the University. University personnel responsible for the preparation and retention of records shall ensure that those records are accurately prepared and maintained in a manner and location as prescribed by law and University policy.

1. The complete and accurate preparation and maintenance of all records (medical, professional, electronic, paper, and institutional) by University physicians, clinicians, nurses, and others are important for providing quality care and conducting business of the University's clinical enterprise. Accurate records are required in order for the University hospital or clinic to retain licensure and accreditation.
2. University personnel will not knowingly create records that contain any false, fraudulent, fictitious, deceptive, or misleading information.
3. University personnel must not delete any entry from a medical record. Medical records can be amended and material added to ensure accuracy of a record in accordance with UC Davis Health and Medical Staff policies and procedures. Whenever University personnel amend a record, they must indicate that the notation is an addition or correction and record the actual date that the additional entry has been made.
4. University personnel must not sign someone else's signature or initials on a record unless they have been authorized and clearly marked that they are signing on behalf of another (e.g. by initialing the signature).
5. University records shall be maintained according to accepted standards and principles of the particular profession and applicable University policies and procedures.
6. Unless authorized by University policy, University personnel shall not destroy or remove any University records from the University's premises.

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7. The University's record retention and record destruction policies and procedures must be consistent with Federal and State requirements regarding the appropriate time periods for maintenance and location of records.

Standard 7 — Cooperation with Government Requests for Information

University personnel should cooperate with appropriately authorized governmental investigations and audits.

1. The University has developed detailed policy to advise University personnel on the procedures to be followed when representatives of the government arrive unannounced. The policy establishes a procedure for an orderly response to the government's request to enable the UC Davis Health to protect itself and its patients' interest while fully cooperating with the investigation.
2. When a representative from a federal or state agency contacts University personnel for information regarding the UC Davis Health or any UC Davis Health affiliated healthcare entity, or any other entity with which the UC Davis Health does business, the individual should contact the hospital director immediately. If the hospital director is not immediately available, the individual should contact the Compliance Office, or UC Davis Health Counsel or General Counsel. University personnel should ask to see the government representative's identification and business card, if the government representative is there in person. Otherwise, University personnel should ask for the person's name and office, address and telephone number, identification number and then call the government representative's office to confirm their authority.

Standard 8 — Prevention of Improper Referrals or Kickbacks

University personnel must not accept or offer, for themselves or for the University, anything of value in exchange for referrals of business or the referral of patients.

1. Federal law generally prohibits anyone from offering anything of value to a Medicare, Medicaid, or TRICARE patient that is likely to influence that person's decision to select or receive care from a particular healthcare provider.
2. University personnel may not offer or receive any item or service of value as an inducement for the referral of business or patients to or from University providers or practitioners or outside facilities. Regulations prohibit improper influence that could alter clinical decisions or purchasing decisions, increase costs, or lead to over or under utilization of services.
3. In addition to the prohibition regarding exchange of goods or money to induce referral, certain prohibitions exist with regard to receipt of gifts by University personnel.
4. Federal law prohibits a physician from referring a patient for certain health services to a facility where that physician (or a family member) has a financial interest (Stark regulations).

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5. University personnel should adhere to the University's policy as defined in the Compendium of University of California Specialized Policies, Guidelines and Regulations Related to Conflict of Interest, the University's Gifts Policy, as well as the California Political Reform Act.
6. Each campus shall establish procedures for the review of all pricing and discounting decisions to assure that appropriate factors have been considered and that the basis for such arrangements is documented.
7. The following types of business arrangements must be reviewed and approved by one or more of the campus executive management teams to assure compliance with University policies and federal regulations. The executive management team may determine that certain business transactions must first be approved, in accordance with University policy, but the University's Board of Regents is charged with taking action on such matters:
 - Pursuing joint ventures, partnerships, corporations;
 - Developing hospital financial arrangements with hospital-based physicians;
 - Entering into an arrangement to lease or purchase equipment or supply items from a vendor; or
 - Acquiring physician's practices, hospitals, and other facilities, clinical, and ancillary services, or any other entities.

Standard 9 — Adherence to Antitrust Regulations

The university will comply with all applicable federal and state antitrust laws.

University personnel should not, for example:

- Agree, or attempt to agree, with a competitor to artificially set prices or salaries;
- Divide markets, restrict output, or block new competitors from the market;
- Share pricing information with competitors that is not normally available to the public;
- Deny staff privileges to physicians or allied practitioners, individually or as a group, when there is no academic programming decision to do so and when such decisions should be based on individual qualifications; and
- Agree to participate with competitors in a boycott of government programs, insurance companies, or particular drugs or products.

Standard 10 — Avoidance of Conflicts of Interest

All University personnel shall conduct clinical enterprise and personal business in a manner that will avoid potential or actual conflicts of interest.

1. University personnel shall not use their official positions to influence a university decision in which they know, or have reason to know, that they have a financial interest. University personnel should follow the Compendium of University of California Specialized Policies, Guidelines, and Regulations Related to Conflict of Interest and be knowledgeable about

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activities that may be an actual or potential conflict of interest. Examples of such activities may include, but are not limited to, the following:

- Giving to or receiving gifts, gratuities, loans, or other special treatment of value from third parties doing business with or wishing to do business with the University in a manner that is not in accordance with the University's Gifts Policy and the California Political Reform Act. Third parties may include, but are not limited to, customers, patients, vendors, suppliers, competitors, payers, carriers, and fiscal intermediaries;
 - Using the University facilities or resources for other than University activities;
 - Using the University's name to promote or sell non-University products or personal services; and
 - Contracting for goods or services with family members of University personnel directly involved in the purchasing decision.
2. University personnel should consult with a supervisor, executive management, the campus conflict of interest coordinator, University general counsel or, if available, campus counsel prior to engaging in any activity that could raise conflict of interest issues.

Standard 11 — Respect for Patient's Freedom of Choice

When referring patients to home health agencies, medical equipment suppliers or long term-care and rehabilitation providers, University personnel should respect the patient's right to choose their own providers.

Some healthcare plans limit the patient's choice of provider or pay less than the full cost of a provider. The patient has the freedom to choose providers not in their health program or insurance plan, provided the patient is willing to pay for the non-covered care.

Standard 12 — Honest and Fair Business Practices

University personnel shall adhere to fair business practices and accurately and honestly represent themselves and the University's services and products.

1. University personnel will be honest and truthful in all marketing and advertising practices pertaining to the business practices of the University's academic health centers and health systems.
2. Vendors who contract to provide goods and services to the University's academic health centers and health systems will be selected on the basis of quality, cost-effectiveness and appropriateness for the identified task or need, in accordance with University policy.

Standard 13 — Fair Treatment of Employees

The University prohibits discrimination in any work-related decision on the basis of race, color, national origin, religion, sex, gender identity, pregnancy, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, or service

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in the uniformed services. The University is committed to providing equal employment opportunity and a work environment where each employee is treated with fairness, dignity and respect.

1. The University will make reasonable accommodations to the known physical and mental limitations of otherwise qualified individuals with disabilities. If an individual requires accommodations or needs assistance, he or she should contact the campus Employee Assistance Program or human resources.
2. The University does not tolerate harassment or discrimination by anyone based on the diverse characteristics or cultural backgrounds of those who work for the University pursuant to the University of California Non-discrimination and Affirmative Action Policy Regarding Academic and Staff Employment.
3. Any form of workplace violence or sexual harassment is strictly prohibited. University personnel should refer to campus specific policies dealing with workplace violence or sexual harassment.
4. For employees who observe or experience any form of discrimination, harassment or violence, the University provides a number of ways to report the incident, including, but not limited to the following: a supervisor, manager, the Chief Compliance Officer, UC Davis Health Counsel, University general counsel, campus counsel, Human Resources, the campus Office of Equal Opportunity & Diversity, the campus Compliance hotline, and appropriate Academic Senate committee.

Standard 14 – Clinical Research

Integrity in research includes not just the avoidance of wrong doing, but also the rigor, carefulness, and accountability that are the hallmarks of good scholarship. University policies set forth expectations for high standards of ethical behavior for faculty, staff, and students involved in research. The rights of research study participants and their well-being and privacy are protected by the University through compliance with ethical standards and all applicable University policies and federal and state regulation.

1. All members of the University community engaged in research are expected to conduct their research with integrity and intellectual honesty at all times and with appropriate regard for human subjects.
2. To protect the rights, well-being, and privacy of human subjects, all research involving human subjects is to be reviewed by institutional review boards.
3. The University prohibits research misconduct. Personnel engaged in research are not to: fabricate data or results; change or knowingly omit data or results to misrepresent results in the research record; or intentionally misappropriate the ideas, writings, research, or findings of others.
4. All those engaged in research are expected to pursue the advancement of knowledge while meeting the highest standards of honesty, accuracy, and objectivity and to demonstrate accountability for sponsors' funds and to comply with specific terms and conditions of contracts and grants.
5. In accordance with University policy (UCOP Operating Requirement No. 95-5, "Requirements for Administration of Agreements with Private Sponsors for Drug and Device Testing Using Human Subjects"), the cost to perform clinical trials conducted for a private sponsor must always be fully

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funded by the sponsor and may not be supported in whole or in part by other funds, including third party insurance payments, gift or foundation funds, or charges to the subject.

6. Goods and services are procured in a competitive, fair and timely manner in compliance with OMB Circular A-110 and University policies. Conflicts of interest are avoided. Educational or research grants or other funds received from commercial entities are not permitted to influence procurement decisions.
7. Ongoing monitoring and auditing processes, with initiation of appropriate corrective action, ensure the University's clinical research programs are well managed.
8. The records retention program for clinical research ensures documents and other necessary supporting evidence are maintained for the appropriate length of time as required by federal and other regulations. This program evaluates and verifies the effectiveness of the systems and internal procedures implemented.